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ABSTRACT

The report describes a special 2-year early oral language intervention program designed by a Wisconsin public school system to develop life-oriented, auditory-vocal language skills in language delayed children. Explained are administrative aspects of the program including evolution of the speech and language disabilities department (1940-74), and methods used to secure school administrator and school board support, and to increase community awareness. Discussed in detail are case finding procedures (referrals and screening), the prekindergarten screening program, and the process of individual needs assessment through parent interviews, observation of children, and multidisciplinary team evaluation. The program is analyzed in terms of its philosophy, procedures (such as structuring the auditory environment, reinforcing essential behaviors, and fostering home-school communication), curriculum (emphasizing art, movement, and music activities), professional and paraprofessional staffing, and housing. Use of nine types of audiovisual equipment (such as slides, videotapes, and polaroid cameras) is explained. Evaluation procedures (such as parent interviews and language tests) and results are examined, and an extensive individual case report is presented. Included are a bibliography and appendixes containing forms used for communication with parents and record keeping. (LC)

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Pre-Academic Program for Children

Delayed in Oral Communication Skills

Joint School District #10

Appleton, Wisconsin

Funded by:

ESEA-Title VI-B

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Division for Handicapped Children

Joint School District #10, Appleton, Wisconsin

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March 1974

To the Reader:

The two year old dumped his cereal on the floor. Hands on hips and foot stamping his mother said, "And just what do you call this?" The child peered over his highchair tray and replied, "toesies!..."

I approached the task of writing this report feeling that it was a wrap-up...sort of a finishing behavior. With each section came new ideas and numerous questions. As the last page is numbered and the last picture glued I call this a beginning.

Although written primarily for the Speech and Language Clinician in the public schools I hope that Administrators, Special Educators, Curriculum Planners and other school personnel will find this report helpful. Our experiences, reported herein, suggest that young language delayed children require special programming. We believe that the evaluation of our program has shown that we have had an educational impact.

During the past three years many people have contributed time and effort to the operation of our Oral Communication Program. Appreciation is expressed to all ... from the baker who frosted fingers to the eleven year old who helped daily. Special thanks to Vernon J. Smith for his counsel and support and to Dolores Skarda and Janet Curran for their help in writing this report.

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Prologue

Picture a fragile 5 year old boy with a limited vocabulary who rarely spoke in an audible voice during the year and a half that he had been in an Oral Communication Center. Language had been fed in repeatedly. Oral responses had been reinforced. Then finally one day as the children were playing a counting game, this little boy opened his mouth and literally shouted the cadence, "ONE TWO THREE FOUR FIVE SIX!!!!!!"

The little boy seated next to him looked up startled. And then with a voice filled with awe he turned to the clinician and said, "Teacher! Teacher! Him not dumb. Him can learn!" The clinician responded, "Of course he can. Didn't you think he could?" The boy replied, "Me no know....but now me know! Him can learn!" What a thrilling moment! The group dissolved in laughter, then they clapped and hugged the little boy with the newfound big voice. The communication barrier for another little child had been broken. He had learned an important lesson.....talking is fun, it's rewarding, it makes you "not dumb" anymore.

This episode, or many similar ones, are enacted often in the six oral communication centers in our city each day. We don't force communication, we encourage it, model it, reinforce it and make it worthwhile and fun--and above all useful in obtaining everyday needs and satisfactions.

Our report contained in the following pages concerns the activities and outcomes of a two year early oral language intervention program developed in the public schools in Appleton, Wisconsin. It is a program

operated within the district's Speech & Language Disabilities Department. Currently we have six self-contained Oral Communication classes in this city of 60,000. These classes meet daily on a half day schedule, and we program for children ranging in age from three to five years. Our purpose is to develop life-orientated auditory-vocal language skills (ie. listening and talking) in children delayed in the acquisition of these skills.

Everybody in education today is vitally concerned with "Johnny" who can't read. Much money and research has gone into finding out why he can't read, and what can be done to alleviate his problem. And yet, in spite of all this effort there are still far too many "Johnnies" who are not reading. Research has plainly indicated that there is a definite hierarchy of the learning tasks. In most cases we must understand before we can talk, we must talk before we can read, and we must read before we can express ourselves in writing and yet, in all the massive educational assault on reading skills, little, if any, attention has been focused on the precursor of reading, ie. auditory-vocal language skills.

We feel that not enough emphasis has been placed on understanding (receiving) and on talking (expressing) while most of the emphasis has been placed on "reading readiness", which usually includes visual perception tasks and phonic drills. It is our contention that a good self-image and adequate auditory vocal language skills are basic to success in reading as well as to an adequate adjustment to daily living. Accordingly two years ago we began an intensive pre-academic oral communication program for young language delayed children.

In these two years we have learned much that we hope to share with

you. We don't have all the answers. But we do have an hypothesis, predicated on our belief that young language delayed children generally present a poor prognosis for later academic success; and that early systematic intervention can greatly enhance their chances of achieving a more satisfactory educational adjustment. As you read on you may disagree with our philosophy, our aims, our goals, or our methods for reaching those goals--and this is fine. We are not claiming that ours is the only way of approaching this task, nor are we claiming that is is necessarily the best way. We do know that we are getting some exciting results. We just want you to start seriously thinking along the lines of early oral language intervention. Once you have begun thinking along these lines, we will have accomplished one of our goals. We sincerely believe that unless the speech clinician can make a significant contribution to the child's total educational process--we are risking professional extinction in the foreseeable future.

But thinking about early intervention is not enough. Certainly there are many grey areas in our present knowledge of how a child acquires language, but we cannot and must not wait for the answers to come pre-packaged to us from the professional researchers in sometimes cloistered laboratories. This knowledge cannot and will not come from these places. For as Paula Menyuk (1970) says:

> "To sum up, the theorist can provide descriptions of the structure of language and the developmental sequences in the acquisition of language. The theorist and the educator together, through experimentation, can observe how adequately these descriptions define and differentiate language deviancy and the degree of deviance. The theorist and educator can, through experimentation possibly derive some explanations for the language behavior observed....The educator can then plan a program which is based on the facts of language acquisition and a particular child's linguistic capacity and competence. The educator can evaluate the effectiveness of

this program by measuring the changes in the degree of deviancy in terms of structural descriptions at the...levels of the grammar that a child is using after a period of time. The theorist and educator together, through experimentation, may be able to devise particular measurement techniques based on linguistic descriptions of language competence, which can be used to define language deviancy, to plan a curriculum, and to evaluate progress in an educational program."

This then is the starting point. Begin with an hypothesis, which will suit your needs and goals. Our hypotheses indicates that in order to make any appreciable contribution to a child's learning, it is vitally essential to identify and remediate his language problems at the earliest possible point in this learning process. Ideally, of course, this intervention should take place in the first two years of life. Unfortunately, idealism does not sell programs whereas reality often does. Reality dictated that, at the time that we initiated our program, we would have to settle for something short of the one to two and a half year old mark. Now, with the new law in Wisconsin concerning mandatory education at the age of three, this area is becoming increasingly easier to penetrate and sell to formerly reluctant boards of education.

Our first priority in case selection is the young child.....the preschool and kindergarten aged child, whose primary exceptional <u>educational</u> need is in speech and language. We feel that this program belongs in the public schools because it is the school's responsibility, in Wisconsin, to provide for children with exceptional educational needs. Further, it is felt that a speech clinician is the most appropriate staff member for this program because the most prevalent observed educational need in young children is a need for speech and language; the precursor of reading.

Administration

SPEECH & LANGUAGE DISABILITIES DEPARTMENT 1940-1974

About this time we hope you are thinking that this all sounds great, but how or where do we begin a program as revolutionary to the traditional idea of speech and language services as the open classroom concept is to the teacher committed to the security and autonomy of a self-contained classroom. Perhaps an historical overview and comments about the present administration of our program would help clear up some of your questions and apprehensions.

Chart #1 summarizes the evolution of our Speech & Language Disabilities Department. When you examine the section on Chart #1 entitled Academic Service, you will note that our caseloads have gone from 227 in 1940 to 35 in 1974. During this time not only the numerical figures have changed but also the number and length of sessions each child attends has changed. Speech and language sessions which previously ran 20 minutes twice a week now average 30 to 60 minutes daily.

During this same time period state department speech reports indicate that for the 1971-72 school year 78% of the children in Wisconsin were seen twice a week, while caseloads averaged 53 for city programs and 58 for county programs. We view with alarm these figures--just as we view with alarm those speech clinicians who have decreased caseload numbers without increasing the number of sessions per week. Our learning theory supports the efficacy of a greater number of sessions. Doubling the time span of speech and language sessions is certainly not doubling the service

CHART #1

APPLETON PUBLIC SCHOOLS

Speech and Language Disabilities Department

March 8, 1974

PRE-ACADEMIC ORAL COMMUNICATION PROGRAMS - AN EVOLUTION

Date	Staff (Fulltime & Parttime)	Case Finding Method	Speech and Language Services (Children)		Speech & Language Staff Improvement
			Pre-Academic Service	Academic Service	
1940's	1	Screened all elementary	None-1 Talk to K. parent group	Caseload: 227	
1955's	2 & 1	Screened all primary	1 parent consult Suggested no help below Pri. 3 unless severe. No direct service.	Caseload: 120 91% Artic. Seen twice a week-20 min. Waiting List 196	
59-60	3	Screened Pri. 3 (& New) Teacher referrals Outside referrals	No direct service. 16 Kgn. parents counseled.	Caseload: 95 88% Artic. 1x or 2x per week-95% c.p.-Daily Waiting List 246	State Assoc. Meeting
65-66	4	Screened Pri. 3 (& New) Teacher referrals Outside referrals	2 children after school hrs. Pre-K booklet-Artic Norms & fluency "Do & Don't"- 3 kindergarteners enrolled	Caseload: 70 77% Artic. Seen 2x per week-95% c.p. Daily	Courses Grad. School and ASHA Convention WSHA Convention area meetings
67-68	4 & 3	Screened Pri. 2 Teacher referred Outside referred	15 C.P. Preschool-2x per week 5 Lang. Del. Pre.-3x-1½ hr. 5 Kindergarteners	Semester Block Caseload: 45 56% Artic. 4 or 5x week-81%	Courses: S.L.D. & stuttering Conventions Area meetings BHC Consult re: selection
69-70	6 & 3	Teacher referral (Given criteria-referral) Outside referral	14 C.P. Preschool-2x per week 4 Lang. Delayed-3x 6 H. of H. Preschool-5x-½ day	Caseload: 40 54% Artic. 4 or 5x-all year-70%	Courses-Except. Children BHC Consult re: screening
70-71	7 & 5	Teacher referral Outside referral Pre-K screen	14 C.P. Preschool-2x 6 Lang. Delayed-3x-1½ hr. 6 H. of H.-5x-½ day 10 older Pre-Acad. (EPPC) 17 Kindergarteners	Caseload: 38 57% Artic. 4 or 5x per week-68%	Conventions Courses: Psycho-linguistics reading, lang. devel. BHC-Consult re: lang. dev.

71-72	9 & 4	Teacher referral Outside referral Community awareness 101 preschool Pre-K Interdisc. Team screen	16 C.P. Preschool-2x per week 34-½ day-delayed lang. Title VI-Oral Com. Center 90 Kindergarteners-5x	Caseload: 40 33% Artic. 4 or 5x per week-75%	Courses: E.D., S.L.D., conventions Dept-In-service 1 hr dept. mtg. weekly re: lang. development
72-73	9 & 4	Teacher referral Outside referral Pre-K Team Screen.	14 C.P.-½ days-5x 76-½ days-5 centers-5x 15-M.R.-2 hr.-5x 15-½ days-Kgn. unit-5x 20-½ oral comm.-½ motor-5x (2 loc) 30-kindergarteners-30 min-5x	Caseload: 35 20% Artic. 4 or 5x per week-75%	Early Intervention Language Disorder courses. 2 hr. dept. mtg weekly State-Consult re: program Div. for Handicapped Child.
73-74	9 & 4	Pre-K Screen Teacher referral Outside referral	12 C.P.-Pre-½ day 5x 96-6 centers-½ day 5x 45-Kindergarteners-30 min 4x	Caseload: 38 4 or 5x per week-80% 15% Artic.	In-service from other school professionals Workshop-lang. development Conventions Course work

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and/or the educational impact. We have found that with intensive service to carefully selected children we get more professional mileage from our staff. In other words we are beginning to see overt signs that show us we are having educational impact.

Your next question is probably, "But what about speech & language services to children above kindergarten age?" This is a good question and one that deserves serious consideration, because when a department emphasizes service to young children there are going to be some rough spots with fellow staff members, teachers, and principals regarding traditional speech and language services. Our present operational procedures have evolved as the chart indicates to the following point: (1) We are selective, choosing only those children who demonstrate an exceptional educational need in the area of speech and language. (Ordinarily we do not have difficulty scheduling a child who is in need if we are helping to fulfill that need.) (2) We provide enough service to have an educational impact. What is educational impact? Briefly if teachers and other professionals ask your advice and cooperation in helping a child or simply if you're missed when you're sick--you've got it made! (3) We coordinate service with the child's total school program; working with the classroom teacher to assess needs. (4) We involve the parents and classroom teachers in the remedial program. (5) We communicate the philosophies and operational procedures to classroom teachers and principals via staff in-service. We are currently developing a video tape presentation entitled, "Speech and Language Services and You." It will illustrate program operations (showing episodes of speech and language sessions at various levels) and guide the classroom teacher and special educator in the referral process. This could be done with slides or written information. We feel a building staff meeting is most appropriate.

When you examine the section in Chart #1 entitled Pre-Academic Service you will note that we have gone from providing no service to young children to an emphasis on service to young children. We have found through screening that approximately four and one-half percent of our five year olds entering kindergarten are delayed in auditory-vocal language skills to the point of needing a half day experiential language development program. Most of those identified attend an oral communication center prior to kindergarten, thus delaying kindergarten entrance one year. Some attend our centers in addition to kindergarten.

Screening has evolved to the pre-kindergarten interdisciplinary procedure described in the screening/assessment section of this report. (pp 17-23) We screen only at the pre-academic level. Casefinding of all school aged children depends on teacher and/or parent referral. Our experience and research indicate that teachers are extremely keen in spotting trouble. It is the responsibility of the speech clinician to educate the classroom teacher in referring appropriate children. The same holds true for parents who must also be informed about the availability of service and informed about referral criteria. Most parent referrals concern very young children, two to four years of age. The section entitled Community Awareness describes the methods we use. (pp 11-12)

Looking at this sketchy history one could say perhaps that it has been a revolution. Revolution to us has some circular properties and no way would we want to go round this cycle again. Instead we cling to evolution...to unfolding...to developing...so that we may have hope for the future.

SCHOOL ADMINISTRATOR & SCHOOL BOARD SUPPORT

This section is sort of a "how to get your program sold and rolling" outline. For reasons of expedition a program administrator is needed whose first responsibility is to secure school administrator and school board support. The program advocate in some cases may be the school speech clinician. In this case it was the Director of Special Education and the Speech & Language Disabilities Department Head.

A proposal was sent to the school administrative team and on to the school board which cited the fact that the community had expressed a need in the area of speech and language services. For several years young children were referred to the school by parents, pediatricians, etc. For several years limited services to preschoolers had been provided. One clinician had a group of five young children who were seen three times a week for an hour and a half. Several young children were served individually through parent training. The program proposal, goals and expected outcomes of the program and budget were presented in writing prior to a school board meeting. At the meeting, a video tape of a four year old boy demonstrating speech and language delay was presented. Also, via video tape, the boy's father was interviewed briefly. He talked about his son's needs and the good results of the limited service the boy was getting.

The Board of Education asked for clarification of their long range responsibility and wanted to know the plan for evaluating the project. It was felt that the Speech & Language Disabilities Department could continue the project at the end of the federal funding. In Wisconsin, there is state funding of 70% for speech clinicians. The board approved the

project application. The two year project was subsequently funded by ESEA-Title VI-B, Wisconsin State Department of Public Instruction, Division for Handicapped Children and the local school district.

Contact with administrators and with the school board was kept through written informational reports. At the end of the second school year a longitudinal video tape showing one youngster's progress, supplemented a report on number of children referred, number identified and number enrolled. At one time a sound-on-slide presentation demonstrating program procedures and philosophies was presented. We feel it is extremely important to communicate with the board and with school administrators. It is well worth the effort to spend several hours preparing audiovisual aids to enable you to get a lot of information across in a short time. We have been encouraged by the interest and support of our school board and respect the investment of their time.

COMMUNITY AWARENESS

While board approval is primary and necessary your program will not get off the ground without community awareness. We used several approaches to inform the community about the new program. The first was a letter sent home with all parents when they registered their child for kindergarten in the spring. The letter announced the program and gave referral information. (Appendix A) Our first referrals resulted from this letter. It seemed helpful to reach these parents, many of whom had friends and neighbors who were concerned about their own children. Newspaper articles yielded other referrals. Once underway, a feature article about the program appeared in The Post Crescent, our daily newspaper. Through this, additional referrals were obtained.

A third method used was a brochure which was circulated to physicians, dentists, health and welfare agencies and nursery schools. (Appendix B) We circulated these brochures only once. The life of the brochure was relatively short. Some copies were placed in offices and waiting rooms. Physicians (notably pediatricians and otologists) and other professionals have continued to refer children over the past two and one half years. The brochure, with a cover letter, was felt to be more effective in informing the professionals, about the service, than in obtaining parent referrals.

There are, of course, other media, ie. radio, television and community contacts such as speaking at Parent-Teacher organizations or community clubs. Each community will vary in the publicity vehicle which works best. It is helpful to publicize at regular intervals. Once the Appleton program was established the greatest number of referrals came from parents who heard about the program from the parents of children enrolled in the program. Parent groups, such as the Aide to Retarded Children, are active in community education regarding special services.

It is extremely important that speech clinicians inform their administrators about needs of children and about their desire and their ability to serve young children. This is a responsibility of the utmost importance. If speech clinicians wish to serve young children, they must prepare themselves through reading, workshops, course work, etc. and then they must stand up and identify themselves to their own school administrators, and to their fellow teachers. It has been our experience that fellow teachers, including fellow special educators and administrators, have been supportive and helpful.

Case Finding

REFERRALS

Referrals from the community, at large, facilitated the identification of children younger than kindergarten age. Initial referrals of preschoolers were timed with the publicity method used. In other words following the distribution of a brochure, referrals would result. The greatest number of referrals during the first year resulted from newspaper articles and a letter given parents at the time of kindergarten registration. During the second year of this project the main referral sources were parents and physicians. Thus far this school year (September to March) there have been 58 referrals of preschoolers. The main referral sources were parents, other school personnel and nursery school teachers.

A referral was extremely easy to make. The parent was advised by the referrer to call the Speech & Language Disabilities Department to make an appointment. It was clear in all the publicity that a referral was a referral for an evaluation of speech and language skills only. Many parents said, "I'm not sure but he isn't progressing in his talking like my other children."--It was clarified that an evaluation would yield an estimate of hearing acuity, vocabulary comprehension, articulation and language skills; and that there would be a parent conference before and after the evaluation.

Parents were often concerned about whether or not the child would talk to the speech clinician. The child oriented environment was described as was the general approach used with children and the experience of the diagnostician. Another parent concern was their own credibility. Many had expressed their concern for their child to the pediatrician, to grandma, etc., only to be told "he'll be all right." In some cases we agreed with

this advice, but in most cases the parent's concern was thought justified. A tally of the diagnostic categories into which these referrals were subsequently placed (after team evaluation and/or longitudinal monitoring) is support for parent credibility. These diagnostic categories included psycho-neurologic language delay, mental retardation, social/emotional immaturity, hearing impaired, hyperactivity and motor disability. The parents of one autistic child had sought the help of others before she called us. In this case, we participated in directing her to an appropriate diagnostic and parent training program. Following this the child was placed in a special program. It should be stressed that diagnostic label was not a selection criteria. Selection depended on demonstrated exceptional educational need in the area of speech and language. Children with severe emotional problems or profound hearing loss were referred on. We felt it was highly desirable to include the young EMR child in our program. We have in our community a program for young TMR children.

The referrer is often interested in the results of his referral. Nursery school teachers were particularly interested in evaluation results and program recommendations. It is suggested that the parent be asked if they wish a report to go to a professional person or agency. If so, a 'release of information' form should be signed by the parent and kept with the school record.

The current Wisconsin Legislation appears to add an extremely important dimension to the referral process. Parents, teachers, physicians, etc., now refer, to the designee of the Board of Education, any child that they feel has an exceptional educational need between the ages of three and

twenty-one. When a young child is referred, he is insured of having an interdisciplinary team make educational assessments and recommendations. Also if speech and language skills appear delayed, the speech clinician would be functioning on the team as a diagnostician and as a person with educational programming abilities in the acquisition of speech and language skills.

Referrals were vital to casefinding. They were more numerous and the resultant cases more diverse than anticipated.

SCREENING

Screening is defined as making particular observations of each member of a population. For years speech clinicians have screened various age levels for various reasons and the bulk of the cases was coincidental with the level screened. In 1967 in Appleton, the Primary II (Second Grade) level was screened. Out of 1,100 children, over 200 were found to have defective articulation. Letters were sent to parents stating that the child did misarticulate a sound or two but that it did not seem to affect his communication or education. A recheck in a year was promised. Parents who were concerned and wanted speech help for their child were requested to call or write the school speech clinician. Less than half-a-dozen requested service! And, in a year, all but approximately 10% had "matured" into conventional articulatory patterns. There were a few brought to our attention by classroom teachers who were having trouble with phonics. These children were enrolled in speech sessions. In 1967, the bulk of our cases were at the Primary II level (Second Grade), in 1968, the Primary I level (First Grade) and in 1971, at the kindergarten level... we had switched to pre-kindergarten screening. We have found teachers and parent referral at other levels an efficacious casefinding procedure.

Children enrolling in kindergarten must be five before the first of December. The Speech & Language Disabilities Department conducted a speech, language and hearing screen in the Spring of '71 for all incoming kindergarteners. The following spring we were part of an interdisciplinary screening team formed for purpose of screening incoming kindergarten children. Last spring we improved our procedures and this year we are improving the improvements. Also, as screening of all students new to the district is now mandatory in Wisconsin, as is a team evaluation of those identified, it becomes a matter of deciding when and where staff time is best spent. All of our speech clinicians are directly involved in planning and screening.

The procedure described in detail in the following section is one which has relevance to this project. The speech clinicians were released for ten half days from regular class sessions for this screening. Evaluation of the children who failed the screen was done during the spring and summer.

To summarize: The Speech Clinicians shall:

a. Have input into the team planning of the total screening program formulating the speech, language and hearing screening measures and procedures to be used.

b. Conduct the speech, language and hearing screen in cooperation with other disciplines.

c. Make a summary listing per school of the children suspected of having an exceptional educational need in area of speech and language.

d. Recheck the hearing acuity of all children failing the hearing screen and coordinate follow-up with school nurses and parents.

e. Participate in multi-disciplinary evaluations of children listed in c. above.

Screening

THE SCREENING PROCESS

Children were registered for kindergarten in March. When the parent registered the child, he was given an appointment time for Round-Up, the name given our pre-kindergarten screening program. Parents were given a letter, at this time, explaining the Round-Up. This year our nurses have added a health history form and our social worker a behavior rating scale for parent input. There were seven screening centers operating at one time in seven elementary schools. We screened approximately 1,000 youngsters.

Eight children were scheduled at one time for ninety minutes. Screening was done by a seven man team. The first year we found that screening all day was too fatiguing for the examiners. Therefore, we now screen two groups, of eight children each, in a half day; one week these sessions are in the morning, the other week in the afternoon.

When they arrived, the children were separated from their parents. It was explained that they would play and that they'd be asked to go with teachers to do some looking and listening and talking. The child was welcomed with a name tag on which was written his name, birthdate and the words: Talk, Listen, Move and See. Upon completion of one of the observations, a word was circled indicating to the team and to the play group monitor that he had been tested in a particular area. This enabled us to see at a glance which one had not been screened in our area. We tried to allow a little playtime in between tests.

Principals were asked to provide the rooms. We used our oral communication centers and our preschool Title I classrooms where possible. In some schools it was a real challenge but "where there's a will". The facility needed was outlined as follows:

1. Classroom size for screening center.
   a. Appropriate playthings, child oriented room.
   b. Need child sized furniture in testing stations.
   c. Acoustics important (echo undesirable).
2. Two small, quiet areas, close to play center, for Speech & Hearing (a minimum of one extremely quiet place was required for hearing testing).

The screening procedure was intended to:

1. Screen the visual and auditory acuity of children individually.
2. Facilitate observation of the individual child's skills in the motor, speech, language, general information, visual-motor and basic concept areas.
3. Make the child's visit to school pleasant and personally rewarding.
4. Allow for a brief glimpse of child's social competence.
5. Allow 16 children to be screened in a half day at one center.

An hour and a half session which allowed for eight children to be screened is summarized by Chart #2.

We have found that the children are much more spontaneous and pleased with their visit to school since we have operated a central play group. (In preference to the parent taking the child from station

to station.) Usually parents went home, or did an errand, as their child was screened at his home school. This arrangement was easier to schedule and children never had to wait for an examiner because they were occupied with their play.

The screening record form for the speech, language and hearing section (Appendix C) was completed (except for scoring of the standardized tests) before the next child was screened. If an adequate speech sample was not elicited this was noted. We then asked the monitor of the play group to observe such a child and record her observations under "comments." We rated intelligibility, voice, fluency, grammar and spontaneity.

ROUND-UP SUMMARY (CHART #2)

Area Screened	Child's Time	Instrument	Screening Done By	Staff Coordinator
Concepts & Motor	20 min.	General info., number, colors, Berry(copying geometric figures) draw-a-man Purdue Motor Screening (selected items)	1 Title I teacher or 1 trained volunteer	School Psychologist, Title I Coordinator & Elem. Consultant
Speech, Lang. & Hearing	20 min.	PPVT, Grammatic Closure, Speech sample, pure tone audiometer	2 Speech Clinicians	Speech & Language Dis. Dept. Head
Vision	10 min.	Snellen Chart	2 Jr. Women Club Members	School Nurse
Group Dynamics	40 min.	Toys, books, clay, puzzles Crayons, paper	1 Speech Aide or Student Teacher	Speech & Lang. Dis. Department Head
Total	90 min.			

A note about the volunteers who functioned on our screening teams. The Appleton Junior Women's Club who cooperated with our school nurses and with the Society for the Prevention of Blindness has been an outstanding group. They helped with publicity and printing, and conducted the vision screening. The other volunteers who participated were trained by the school psychologist. They were, for the most part, former teachers, wives of principals, etc. We called them select volunteers. They, too, were a fine group to work with.

FOLLOW UP

We screened approximately 1,000 children. The follow-up procedures (agreed upon by the committee prior to the screening) included:

1. Each area listed the children identified as having a suspected exceptional educational need or acuity deficit per school.
2. Vision rescreening was done by the Junior Women's Club with the cooperation of the school nurses. There were subsequent referrals to eye specialists.
3. Hearing rescreening was done by the Speech Clinician one month after the screening. A threshold audiogram was written. There were: children identified as having a hearing loss; those who were already under care; those who were referred to physicians, and those who had no hearing loss. The Division for Handicapped Children authorized payment for a diagnostic evaluation, to an otologist, for twelve newly identified cases.

4. The Round-Up Committee met and reviewed the children identified. There was a high correlation among the various measures. Summary sheets of findings were compiled, by school, for the building principal and discussed with him.
5. After Round-Up children were enrolled in Title I Summer School classes and 101 children had an individual speech and language evaluation during the summer. See section on case selection for details of this diagnostic session.
6. The following placements were made, with parent consent, prior to school opening.
   a. 47 children were enrolled in our pre-academic oral communication program. Most of these children attended only this class. Some children attended kindergarten in addition and thus were in school all day.
   b. 45 children were enrolled in our Title I preschool classes.
   c. 30 children attended nursery school or stayed home. These had fall birthdays but no particular area of concern.

This year we are planning to do our multi-disciplinary team evaluation the last two weeks of the school year. This will enable our programs to begin on the first day of the school year. It is important to communicate with school principals who have the placement authority. Principals need to know the recommendations early enough to facilitate their kindergarten placements. Some principals participated in making the recommendations to the parents. In other words, principals need to know which children are not going to attend kindergarten and also need

to know which children must be placed in a particular kindergarten session (the opposite half day of the oral communication class). With this in mind, you will note that it is necessary for us to do our multi-disciplinary team evaluations in the spring or summer.

COMMENTS

The procedure just described is one which appears to suit our community at this time. It is felt to be assessment in nature rather than solely a screening procedure. We have examined and are continuing to examine various screening instruments. For instance, there are screening instruments published which place a child on a curriculum continuum. The screening serves to identify children with exceptional needs but also places all children screened on a particular rung of the curriculum ladder. Other screening procedures we have looked at are far less time-consuming than the one described. We discussed possibilities of "quick screens" but did not decide in their favor. We intend to do a longitudinal evaluation of our screening procedures. We feel that it is vital to the successful identification of those children with exceptional educational needs in the areas of speech and language, to have a speech clinician do not only the follow-up but also the initial screening procedures. By reserving the professional staff for only follow-up work, we run the risk of other educators determining our role within the school.

It is our contention that some children should wait to begin kindergarten. Initial school success colors a child's attitude toward himself for all of his school years. Over-placement (beginning kindergarten before he is ready) of a child who <u>does not</u> have an exceptional educational need may cause a child to rate himself poorly

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as a student. The trend among parents and educators in Appleton appears to favor holding some fall birthday children (especially boys) back a year. It should be reiterated that we believe strongly in early intervention programs for children with exceptional educational needs. Placement in a program in lieu of kindergarten also defers kindergarten attendance for a year; this has been shown to be a beneficial situation for many of our language delayed children. The proper time to begin kindergarten is discussed carefully with the parents. The easiest time to intervene is before the child begins kindergarten. We believe that children should not have to fail in order to identify themselves as children with exceptional needs. Our screening/assessment procedure has helped in this respect; it is an important aspect of case finding.

Individual Needs Assessment

In the preceding sections we have outlined the two major efforts made at case finding, namely screening and community awareness. In this section we will discuss the child's speech, language and hearing evaluation which is currently a part of our multi-disciplinary team evaluation. When a child was referred for evaluation of speech and language skills, he and his parents were seen by two speech clinicians simultaneously. An hour to an hour and a half was allowed for this evaluation. Usually the child was seen in the same room as his parents. In just a few cases, such as that of an extremely manipulative child, the parent was interviewed in another room.

The room was large enough to allow for the parent interview in a "corner", while the child was being observed either as he played or in a formal testing situation. In most cases the children communicated well with the observer, appearing assured because the parent was close at hand and occupied. We tried to make the situation appealing to the child. Toys, chalkboard, pets, and water were found to be of universal appeal to young children. We tried to make the situation appealing to the parent by having conference furniture (a rocker and two library settees) in a conversational arrangement.

The assessment of individual needs was divided into two parts: (1) observation of the child and (2) parent interview. These two things were done simultaneously after which the two speech clinicians met with the

parent to discuss impressions, recommendations and follow-up.

BEFORE THE APPOINTMENT

Most of our appointments were scheduled by phone. We were amazed that all appointments for three and four year olds were kept even though they were made three or four weeks in advance and not confirmed. Some were rescheduled because of sickness. We had less success with appointments made as a result of our pre-kindergarten screening. It soon became standard procedure to confirm these a day or so in advance.

When the parents called for an appointment, their main concern was discussed briefly to give us a rough idea of the child's level of development. The parent was told about the nature of the interview and that we would be talking about the child's overall development. Subsequently some came armed with their baby books which proved very helpful. Photo albums, too, aided some parents to associate age and skill. In cases of extremely nonverbal children the parent was requested to bring a written listing of the child's verbatim utterances and note the context in which this occurred, familiar objects to aid in language and hearing assessment were also requested. The parents were told that the child did not need to name the object, but to bring an object if the child could "run and get it from the other room." In a few cases, such as in the case of a voluntarily mute child, the parent offered to bring a tape recording of the child's speech. All of the above helped insure the success of the initial interview.

THE PARENT INTERVIEW

The Speech Clinician doing the parent interview recorded information on the parent interview form (Appendix D). The interview was divided into six sections. Parents were asked to supply: (1) Identifying information. (2) A statement of their main concerns. (3) Speech, language and hearing history. (4) An estimate of current communication skills. (5) An estimate of self-help, social and/or motor skills. (6) A statement of their expectations of the school.

Many parents stated that this was the first time a professional sat and listened to them talk about their child for an hour. It was interesting to note that some became noticeably relaxed as their observations were accepted. Evaluative or remedial statements were not made by the interviewer unless directly requested by the parent. This initial interview was simply an attempt to begin to know the child (educational needs assessment) and to contribute thoughtfully our part of the multi-disciplinary team evaluation.

OBSERVING THE CHILD

The child's verbal and nonverbal behaviors were observed. Standardized tests were used when appropriate. The choice of tests and other behaviors observed depended upon the child's maturity, his reaction to the interview situation and his estimated speech and language level. Under this structure one area might be more closely investigated than another. We made some determination of the child's ability to identify and label, string words together and follow directions, his intelligibility and an estimate of the child's self-image as a communicator...or if you prefer, his receptive & expressive semantic skills, his expressive and

receptive syntactic skills, his phonologic system and his relating ability. We felt it was important not to predetermine but to select from this battery of "tests" when the child presented himself. We attempted to make these observations regardless of whether he communicated verbally or through some other means. The question was, "Does he communicate; and how?"

The following is a listing of some of the options we had available to us in making our assessment. In all cases, we included a minimum of one of the following observations in each of the major areas listed.

I. Speech, Language & Hearing Evaluation Procedures:

A. Semantics

1. Clinical observation.
   a. recorded utterances and responses.
   b. follows directions.
   c. ability to name.
2. Peabody Picture Vocabulary Test.
3. Auditory Reception-ITPA.
4. Boehm Basic Concept Test.
5. Verbal Expression-ITPA.
6. Observe level of classification.
7. Auditory Association-ITPA.
8. Zimmerman Language Scale.

B. Syntax

1. Analysis of Speech Samples.
   a. clinical observation. (Write down verbatim utterances)
   b. tape speech sample.
2. Object manipulation.
   a. child responds by performing.
   b. child tells what he did or what clinician did.
3. Northwestern Syntax Test-Receptive & Expressive.

4. Grammatical Closure-Sub-Test of the ITPA.

5. Verbal Expression-ITPA.

6. Observing Child's Level of Communication.
   a. gestures mainly.
   b. uses single words.
   c. uses sentences like melody and stresses with a few intelligible words.
   d. combines words.
   e. uses functionally complete sentences.
   f. uses structurally complete sentences.

C. Speech Assessment

1. Articulatory assessment.
   a. competence.
   b. consistency.
   c. stimulability.

2. Intelligibility.

3. Fluency.

4. Voice.

D. Audiological Assessment

1. Pure tone assessment.

2. Play audiometric techniques.

3. Speech reception assessment-Clinical Audiometer.
   a. point to body parts.
   b. point to familiar objects.

II. Developmental Profile-Of self-help, physical, motor, social and academic skills

A. Clinical observation of child.

1. Managing his own clothing.

2. Drawing, walking, hopping, catching, copying geometric designs, etc.

B. Parent interview using the Alpern-Boll Developmental Profile Manual.

Evaluation of the communication skills of young children is challenging. Our speech clinicians found the following procedures help to facilitate communication between themselves and the young child:

1. Take time to establish rapport as you start evaluating.
   a. use humor. (verbal and nonverbal)
   b. do not approach the child with questions.
   c. observe his reaction to you and to your proximity.
   d. begin by observing the structure of his play.
   e. make him an immediate success by requesting nonverbal responses. (pointing to pictures, or handing the observer an object or drawing etc.)
   f. enter into a role playing situation with the child.
2. Reinforce desired behaviors.....use of a nonsocial reward may save time.
3. Be flexible--do not have a definite procedure in mind.
4. Be observant--record verbatim utterances.
5. Be natural and set the environment up to encourage spontaneity.
6. Be a good communicator yourself--communicate with the child. Take clues from his communication method. Using appropriate language level, gestures etc.

SUMMARY: INDIVIDUAL NEEDS ASSESSMENT

Following the child observation and the parent interview the information from both sources was pooled. The information from testing and clinical observations were shared with the parent along with recommendations for follow-up. In some cases a second diagnostic session was necessary. The follow-up recommendations included:

1. Enrollment in our Oral Communication program.
2. Referral to another one of our school programs.
   a. kindergarten.
   b. Title I preschool program.
   c. Special Education programs.
3. Referral to an outside agency:
   a. physicians (pediatricians, ENT, neurologist, family, psychiatrist, ophthalmologist).
   b. Community Guidance Clinic for parenting training.
   c. Medical Center Clinic (medical multi-disciplinary team evaluation).

4. A change in home environment and/or parent behavior.

   a. remove failure, assess parent expectation.
   b. reinforce fluent speech.
   c. increase language experiences.
   d. increase child's success rate.

5. No recommendations (child was an effective communicator; parents needed reinforcement.)

It is important that parents be given adequate information to enable them to follow up. They should know precisely which school people will do what and when. If referral was made to an agency or specialist, names and addresses were given the parent, for instance, a listing of physicians from which they could choose. A report of the findings and recommendations was written and sent to the referrer, the school or the agency indicated. Parents signed Release of Information forms.

With the advent of Chapter 89 the Speech Clinicians are now integrating their evaluation and planning efforts more fully with fellow professionals. The speech, language and hearing evaluation procedure just outlined will evolve and mesh into a team effort.

MULTI-DISCIPLINARY TEAM EVALUATION

We are just in the process of implementing multi-disciplinary team evaluations for the children suspected of having exceptional educational needs. These children were identified through our pre-kindergarten screening program (See Section IV). Our psychologists, in this year of '89 (Chapter, that is) have an extremely heavy work load as do all special educators and pupil services personnel. We are now formulating a plan which will enable us to see parents and children for an adequate time. The children will be seen by a team of people trained in assessment

of educational needs and in programming. Team members will be chosen from psychologists, nurses, social workers, consultants, kindergarten teachers, special educators, principals and speech clinicians. Instead of asking the parent to bring the child to see team members individually, we are going to have an entire team see the child and parent on one occasion. Our Director of Special Education appoints a case manager. If the child appears to be delayed in speech and language, the case manager may be the speech clinician. The case manager then chooses team members for that particular child.

One format the speech clinicians are suggesting to other screening committee members, is to have several children come to a central "play group"--children could be taken out for individual assessment or observed in the group. It may be helpful to have some children in the play area who are not being evaluated ie. children not suspected of having exceptional educational needs. Parents would be interviewed simultaneously. Video tapes and/or polaroid pictures of the children and parents would aid in subsequent team discussions. The team would write a program recommendation. Parents would be invited back to discuss team findings and recommendations. If the parent agrees, then a parent consent form for placement would be signed. The program would be implemented in September.

It is feasible in Appleton to begin early intervention programs in September for those identified through pre-kindergarten screening. We screen in March and rescreen and evaluate in spring and summer. This year, as we must screen <u>all</u> incoming kindergarteners, we are planning a second Round-Up in August for late registrants. (New residents and those who missed the March screening.) Also, our Title I program conducts a six

weeks summer session where they get acquainted with and begin helping students with special needs (perceptual-motor and general readiness) in certain of our schools. We support Spring screening and spring and summer team evaluations to enable intervention programs to begin the first day of school in the fall.

ENROLLMENT AND PLACEMENT CRITERIA

The recommendation to enroll a child in the program depended upon the results of the evaluation process (ie. needs assessment). Parent evaluation was a major contributing factor to this evaluation of need. The selection criteria are listed below:

1. The child who was delayed one year or more in two or more of the following:
   a. Receptive vocabulary skills.
   b. Expressive vocabulary skills.
   c. Receptive grammar skills.
   d. Expressive grammar skills.
   e. Articulation skills-consistency of performance.
   f. Intelligibility of verbal and nonverbal language.
   g. Self-image as a communicator (ie. non-communicative).

   (Note: Isolated delay in one of the above was rare.)
2. The child who appeared mature enough to be away from his parents for two and a half hours per day.
   a. Some young children (three years of age) were enrolled on a trial basis. None withdrew as they met only success.
   b. Toilet training was not required.

Parent interest in the program was 100% for the three, four and five year old children who were referred individually. Parent interest in the

program for children, referred by way of the kindergarten screening process, varied from highly interested to unconcerned. Parent approval was necessary for enrollment in an Oral Communication program. In cases where parents insisted on kindergarten placement, the child was placed in kindergarten. In most of the cases, the kindergarten teacher re-referred these children within a very short time. Some parents then reversed their decision, some did not. Some of the children who were enrolled in Oral Communication Centers, following pre-kindergarten screening and evaluation, were delayed one year in kindergarten entrance. Some were enrolled in kindergarten in addition to the oral communication program. These children who were placed in a full day program, ie. one half day Oral Communication Center and half day regular kindergarten; tended to be the more mature enrollees in our program. Also, their progress and adjustment was monitored and a half day placement substituted if appropriate. This decision (for half day or all day placement) was based on the child's physical maturity. Some children couldn't handle a full day in school.

Placement was ordinarily in the class closest to the child's residence unless the child had no language peers within the center. This was feasible as we had six Oral Communication Centers operating. However, it should be stressed that most classes are multi-age units of three, four and five year olds. This is felt to be most desirable.

Young children are enrolled in school in the same manner as all children. Attendance records, individual cumulative folders, insurance, health exams etc. are all standard procedures. The oral communication class is part of the total school curriculum, being a pre-academic auditory-vocal language development class for children with exceptional educational needs in the area of speech and language.

Program

PHILOSOPHY

Is language acquisition innate as the nativists believe; or is it limited and controlled by our environments as the sociolinguists contend; or is it largely a matter of S-R as the psychologists would have us believe? These and other questions are now the subject of research in laboratories and learning centers across the nation and around the world. Development in these areas should certainly be followed closely by those of us who expect to make any impact on a child's language learning. Our professional responsibility dictates that we become conversant in such fields as child development, psycholinguistics, and learning theory, as they apply to the children we will find in our classrooms.

However, often research does not suggest practical philosophies concerning educational management of language deviant children. The establishment and implementation of such philosophies and programs is our responsibility as educators. Therefore, one of the first concerns in setting up a program for early oral language intervention would be to set up a working philosophy, one in which <u>you</u> believe and which <u>you</u> can translate into an educational program.

It is <u>our</u> philosophy that children delayed in auditory-vocal language skills learn language in the same way as other children. We feel that the difference in our language delayed children is a difference in the rate of their neurological maturation. Lenneberg has done research that indicates that this is indeed the case in retarded and hard-of-hearing....

However, while Lenneberg gives no emphasis in this study to environmental influences, we feel that the neurological lag is compounded by environmental influences.

It might be well to be more explicit. We believe that children mature at different rates in the area of language acquisition. This rate may, or may not, be related to maturation in other areas. For instance, a child may sit up, creep, walk etc. at normal times in his development, and yet exhibit a significant lag in acquiring a language system. While delays in sitting up or walking cause immediate concern to most parents, the child's inability to interpret or imitate prosodic patterns (at six months of age) goes by unnoticed. Students of language learning know that by the second year a child's words or phrases should be marked by declarative, emphatic, and questioning intonations. By the third year most children are producing sentences that may be agrammatical, but which are quite complex and easily understood by the people in their environments. We know this, but some parents do not; and they are often assured by relatives and others that this is not unusual and that their child will "probably outgrow it and talk when he is ready."

However, as the child reaches his third or fourth birthday, the parent becomes increasingly aware and upset about the child's inability to acquire speech as his siblings and/or peers have. It is at this point that the parent often actively begins to search for outside help. Now we see the frustrated and guilt-ridden parent bringing the three year old language delayed child to us for an evaluation, hoping that we can do what maturation and parenting have thus far failed to accomplish. Interestingly, most of these parents, while realizing that the child has problems, do not

realize the extent of his problems. They are trying to communicate with him as they would with a "normal" three year old, when it perhaps would be more appropriate to talk to him as though he were much younger.....as indeed he is, in the auditory-vocal language timetable. This is a natural error because the child is communicating with them in his own way and on his own terms. He becomes very adept at interpreting and using gestures to manipulate and control his environment. He also is proficient at extracting environmental cues that the parent is not even aware of. Thus many parents must actually be shown that without the gestures and environmental cues the child is often unable to carry out the simplest commission when the input is purely auditory.

So here we have a child with a severe auditory-vocal language deficit and a guilt-ridden parent blaming himself for not recognizing or doing something about the child's problem sooner. The parent may even be feeling inadequate in his parent role. It is often helpful to tell the parents at this point that this particular child would be language delayed even if he had been raised in a different home. This is said in complete honesty, not to alleviate parental guilt feelings. And the reason we can say this to a parent goes back to our philosophy which states that a child's auditory-vocal language problems are caused primarily by a neurological timetable which has been set at a different maturational speed than the one followed by a child who acquires his language normally.

In other words, when the child was ready to respond auditorially, the parental input was already so complex that the child was not able to abstract the regularities and rules from his auditory environment in order to acquire a language system of his own.

Therefore, while we on one hand exonerate the parent because he cannot, and should not, hold himself accountable for the neurological lag his child is experiencing; on the other hand we are making him the "fall guy" by telling him that he has certainly contributed to the child's problems by cluttering up the child's auditory environment. The child often has no choice but to tune out. The clincher then comes when shortly after making him the "fall guy", we inform him that he may also be a major contributor to the solution of his child's problem.

The solution involves two important aspects of the philosophy underlying our oral communication centers. The first point we stress is that language learning is possible if the parent is willing to change the auditory environment of this child, and if he will reinforce communicating behaviors. Our second point is that both the parent and the school must learn to be adaptable and capable of expecting changes in this child. Both of these points will be treated in more detail in the section immediately following this one entitled "Procedures".

Although we had spent considerable time and effort in arriving at a philosophy that we felt sure was sound both in theory and in practical application, we know that philosophies don't really sell programs..... results do. At the time we began this program, it had not been tried on a large number of children. However, during these past years, we have seen any number of tuned out, nonverbal children become self-confident, happy communicators. They have become so, we believe, because we have simplified and structured their auditory input, and have repeated, modeled, expanded, and rewarded their auditory-vocal output, no matter how primitive or meager it might have been at the start. We have taught and cajoled parents into joining us in this venture through demonstrating to them that the payoff is a communicating child.

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When we started this program we often had to do a "hard sell" to get parents, educators (and yes, even fellow clinicians) to believe that our philosophy was not only valid but also promising and workable. Now, some years later, we find that these same people who went along reluctantly at first are the advocates of our program. Thus philosophy became truth and reality.

PROGRAM PROCEDURES

Program implementation evolved from our philosophy and was implemented through the following procedures:

1. Each child was evaluated and programmed for individually.
2. Evaluation and needs assessment were ongoing procedures which involved both the home and school communities.
3. The child's auditory environment was our main area of concern. The auditory environment in the school setting was the concern of all adults. It was structured to provide:
   a. Auditory experiences.
      (1) Input was simple.
      (2) Input was conventional in form, vocabulary and expression.
      (3) Input was in short phrases and sentences.
      (4) Input was timed with child's experience (parallel talk).
      (5) Input was ample.
   b. Abundant redundancy of language forms (ie. exemplars).
      (1) Modeling.
      (2) Expansions.
      (3) Descriptions.
      (4) Narrative.
      (5) Audio-visual equipment.

4. Our daily program was life oriented and child involved (considering the "whole" child).
5. Firsthand experiences (multi-sensory) were provided each child to enable him to form concepts to which he subsequently attached labels.
6. Reinforcement of essential behaviors was thought necessary to language learning. We reinforced:
   a. Attending.
   b. Imitating.
   c. Listening.
   d. Communicating.
   e. Talking.
   f. Desired social and self-help skills.
7. The school program provided each child with success.
8. Children of a three year chronologic age range (three to five) lived and learned together with adults in a school setting. Peer interaction, reaction and identification were felt to foster language learning.
9. The home environment is crucial. Home-school communication was fostered through:
   a. Daily newspaper.
   b. Visits to school.
   c. Individual parent/teacher conferences.
   d. Parent group discussions.
   e. Specific parenting guidelines.
      (1) Structuring parent communicative behaviors.
      (2) Self-help skills.
      (3) Discipline.

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10. Oral Communication Centers operated as the initial school program for children with exceptional educational needs. This program is a part of the continuum of services available to children with exceptional educational needs and as such is coordinated with programs for the mentally retarded, emotionally disturbed, orthopedically handicapped, hearing impaired and special learning disabilities as well as with kindergarten programs.

CURRICULUM

Units of the curriculum were chosen by each speech and language clinician according to the needs and interests of the children and staff. A unit topic, such as foods, tools, containers, toys, etc., provided a meaningful core. First hand experiences, grammar examples, sound discrimination and listening activities evolved from the unit. Chart #3 illustrates a daily lesson plan for the group. Individual children were assigned to small groups depending on their language competence and needs. The auditory environment was structured differently for each group. A group could consist of one individual. Children who talked in single words or who were beginning to conjoin words were talked to differently than children who used simple sentences of conventional word order. The difference was in sentence length and complexity. Conventional grammar and intonation and stress patterns were used.

As you inspect Chart #3 (from 9:15 to 10:05) you will note that as the groups rotated the adult remained with a particular activity. This became a favored way to plan the daily program. The other alternative being that the adult would stay with one particular group and would guide the children in that group to various activities. Some very young children seemed to need identification with one adult for a number of days. After a time these children generalized that all adults at school were reinforcing; they seemed at ease and appeared to trust all adults in the school environment. To reiterate, we found it generally more workable to assign a particular topic or area to one person (music, number experiences, puzzles, etc.) and have that person suit his language usage and expectations to individual children and/or small groups. This plan allowed an adult to become more conversant with the scope and sequence of a particular task and to assess an individual child more realistically against the entire group in terms of where he is and where to take him next.

Another aspect of programming concerned assignment of individuals to an adult during large group activities (playtime, nourishment time, gym, etc.). The staff member was assigned an interpreter's role at times... paraphrasing, stimulating, demonstrating, etc. At other times this special attention provided reinforcement of particular behaviors such as imitating, buttoning, articulating, following commissions, etc. Each day included time for the children to relate only with other children. It is felt that one of the best features of our school program, for young language deviant children, was the peer relationships which were fostered. Children were able to teach other children and to make friends.

The following sections entitled "Self, Art, Music and Movement Education" are included as illustrations of parts of a well rounded experiential language development program. One could go on infinitum with topics such as temporal learning, number concepts, self help skills, etc. Suffice it to say that this section on curriculum is meant to supply some illustrations of practical ways to put the procedures outlined in the preceding section into practice. Chart #4 entitled "Cooking as a Language Experience" is included as an example of a particular clinician's special interest which provided meaningful first hand language experiences for the children.

We kept in mind that our children needed structure and success. There were many benefits from consistent format although we had to remain flexible and remain active in listening and communicating with the children and their families. In planning the curriculum the speech and language clinician kept in mind the make-up of his class; that is age, boy-girl ratio, interests, background and experiences. Some acquaintance with the home environment of each child is deemed essential.

CHART #3

SAMPLE OF DAILY SCHEDULE

Unit: Containers

Time	Child's Activity	Method	Media	Purpose	Staff
8:45 to 9:00	Arrival-Take off outer clothing. Choose play or listen.	Individual	Clothing Listening Center(Sound-on-Slide) Toys	Self-help skills Vocabulary Make choices	Teacher Aide Student Teacher
9:00 to 9:10	Respond vocally to Roll Call. Attend to announcement of day's activities.	Total Group	Pictures of absent children.	Concept of absent. Learn names of classmates. Structure day.	Teacher
	From 9:15 to 10:05. The children rotate to all four activities. Children are grouped by language level. Purpose and adult language usage varies accordingly.				
9:15 to 9:25	Assemble toys and objects.	Small Group A. Mike Billy	Train track. Stack & linking toys. Bottles & caps, boxes & covers.	Eye-hand coordination & experience.	Children by selves in play corner.
9:30 to 9:40	Listen to described pictures. Find things named.	B. Steven Joey Sherry Don	Slides of tomorrow's field trip to shopping center.	Temporal: Tomorrow. Vocabulary. Prepare for trip.	Teacher
9:40 to 9:50	Describe container in which the penny is hidden. Take turns.	C. Mary Wendy Kevin Brian	Penny, boxes, bags, cans, jars.	Vocal express. Child leader. Hides penny. Describe locat. Take turns.	Aide

9:55 to 10:05	Attends to auditory events. Discriminates: Finds smaller, fatter, etc.	D. Brad Andy Karl George Kurt	Containers, toys & objects of diverse size & texture.	Provide many exemplars of comparatives: bigger, softer, smoother, skinnier.	Student Teacher
10:10 to 10:30	Snack Free play or listen	Total Group	Crackers & milk containers of various shapes. Toys. Sound-on-Slide.	Peer communication. Wh-questions. Nourishment. Socialization.	1 adult
10:30 to 10:40	Clean up.	Total Group	Duty assignment via picture chart.	Assume responsibility & learn helping skills.	All
10:40 to 10:55	Show & Tell	Total Group	Objects and news from home.	Exemplars of multiple attributes. Self concept. Socialization.	Teacher Aide-Puts news in "paper". Student Teacher: Andy Steve Artic.
11:00 to 11:20	Following directions with body in gymnasium.	Total Group	Large boxes 1 per child	Movement educ. Walk around Stand in Sit on Lift up	Physical Ed. Teacher (others help individuals)
11:25 to 11:30	Review day Predict tomorrow Sing	Total Group	Line drawings of day's activities. "Good Bye" song	Line drawing on chalkboard of activities. -numbered- Good Bye Song	Student Teacher Aide-help Billy dress Teacher-reinforce Sherry Contribution (use newspaper)
11:30 to 11:45	Dress & Depart Take newspaper and belongings.	All Individuals	Clothing Show & Tell objects Newspapers	Self-help(zip, fold) Possessives Home-school communication	Check on parent help for tomorrow

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SELF

Many children enrolled in our oral communication program lacked self-identity or lacked a positive self concept. The individualized curriculum and reinforcement of the individual child helped each child identify himself and think more highly of himself. Procedures which fostered a positive self concept included:

1. Removal of failure.
2. Increased success by providing an environment in which the child can succeed, ie. have realistic expectations and the ability to analyze tasks.
3. Praise for individual accomplishment.
4. Value his communication by listening to him and communicating with him; value his name and his photograph through use of polaroid pictures, slides, family photos, etc.; value his possessions, label his school supply box and his coat nook; value his contributions (talking, show & tell, etc.); value him.
5. Provide opportunity for each individual child to make free choices.
6. Provide opportunity for communal living (share food, help keep order and so forth).

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Many of the above procedures were implemented through art, music and movement experiences. We feel that all forms of self-expression are interrelated and because of their further inter-relationship with the growth of each individual child we will outline some philosophies and procedures in the areas of art, music and movement. They have been developed under the guidance of fellow educators in these specialized areas.

ART EXPERIENCES

Developing a child's image of himself is a major goal of art activities in Oral Communication Center classes. Children are encouraged to become more aware of the world around them and react to it in their use of materials. Simple materials such as paint (finger and brush), water, clay and paste are most successful. To children of this level, the experiences with the substances is most important. They are not as concerned with the product as adults are and should not be made to feel concerned. Children may be encouraged to tell about his pictures, but no one is pressured, during any aspect of an art activity. Acceptance of whatever a child produces, praising it honestly, contributes to a child's sense of worth. Children feel pride in seeing their work displayed in the classroom. The individuality of the work lends to a colorful and motivating atmosphere. It is not appropriate to display stereotyped materials; turkeys, santas, easter bunnys, etc., or to suggest that the children make stereotyped forms following a prescribed pattern.

An awareness of children's general stages of artistic development is necessary. It is exciting to notice when a child begins to draw human forms, when previously he was at the scribbling state. This is not to imply the scribbling is inferior, if that's his stage of development. Each child is accepted in those terms and encouraged to do his best at that level.

Much spontaneous talking occurs during art activities. The children talk about what they need, what they're doing and with each other. Many children who otherwise tend to be nonverbal become quite communicative during this time. In keeping with our program goals the children learn the vocabulary relating to art: materials, tools, action words, color, texture line, direction, shape, space, etc.

Children develop skills in the process of creating using this approach. They learn to use a variety of materials and tools by doing in a free atmosphere, with available help from adults. For example, many of the children had never used scissors before their experiences in class. For those who are ready for this activity it was the clinician's responsibility to be aware of any left-handed children, providing them with special scissors, and helping them remember to seek out these scissors the next time they cut. Otherwise, frustration would result and the child would be dissatisfied with himself and feel: "I can't do it". An understanding clinician also realizes that each child needs a different amount of time to develop his own solution to the task.

Through this approach to art activities each child feels a sense of satisfaction with his accomplishments concurrent with a sense of self worth. It becomes obvious to the clinician that the doing is of primary importance to the young child. It was always interesting to watch a child who had painted a recognizable form enjoy obliterating it by painting one solid color over the entire surface.

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MOVEMENT EXPERIENCES

During movement time in Oral Communication Center classes the children learn an awareness of self through individual motor activities. They begin to identify and understand themselves and what they are capable of doing. Movement time involves listening, understanding and implementing directions regarding their own bodies. The vocabulary involved has many practical applications in everyday life.

All children are active during movement time, each working according to his own ability within the prescribed limits of the activity. The half hour sessions begin with a warm up, which is teacher directed and demand close listening. Next is movement training. Activities usually center around a theme, such as space, levels, balance, etc. Then the children work with small equipment (balls, ropes, hoops) again involving the theme. Relaxation training is the last activity of the session. This is something most children must learn to do and has valuable carry-over during the rest of the day. Throughout each activity the vocabulary and concepts of movement are stressed. Clinicians have found if they schedule movement education early in the session the children are more attentive the rest of the day. Activities that involve competition are not appropriate.

The children are taught through physical activity, instead of teaching physical skills. Skills are learned, but this is not emphasized at this level. They learn that their heads control their bodies, and that they can control themselves. An understanding of movement begins to develop; that all movement is not the same and what makes one movement different from another. Eventually they learn to build sequences of movements. The children achieve a lot of satisfaction in learning to control their own bodies; aside from the real pleasure of just moving. As a result, their concept of self is better defined.

There are many extra benefits from such a program. For example, as concepts of space are taught, the child learns about "self" space, and can respond to the direction, "Stay in your own space!" Socialization experiences which are part of daily activities are also taught through physical activities. Children are taught to work with partners, in small groups and large groups, taking turns, respect for other people, and proper handling of equipment.

All of this takes place in a creative atmosphere, where children are encouraged to experiment with movement, but also expected to work at times within structured activities.

MUSIC

Music is another communicative behavior which helps children develop both their oral language and their self-image. Along with movement and art experiences, songs and musical experiences help children learn in a variety of ways. The clinicians own "light happy voice" is the best instrument to help children use their natural clear voices. If the music session is conducted in a relaxed atmosphere, there will be no "strained" voices among the children. Most of our Oral Communication Centers have songs to begin and end the program each day. They provide the children with an element of structure. It's interesting to note that the children will not let the clinician forget to include these songs in the day.

Simple meaningful songs of different types were sung and the same song was repeated often. Songs which have a lot of repetition of simple melody coupled with simple phrases were used; songs such as "Thumbkin", "Happy Birthday", "This is the Way We Wash Our Hands". In a song such as the latter the children were encouraged to imitate the natural gestures and to suggest words and/or gestures themselves for the song. It was our feeling that the gross and fine motor imitation which was facilitated through singing laid the groundwork for articulation improvement and free expression. Some children who were initially nonverbal in class started singing as a first step in beginning to communicate orally. Pictures and objects were used to illustrate meaning. Music and movement education were often combined. For instance, the child would move in time with the drum. Or the drummer may play to the child's movement. With some of the five year olds it was fun to listen and move according to the tone. For instance, the children moved in a low plane (close to the floor) when they heard a wooden clacker, they moved in a high plane when they heard the tone of a metal triangle. The tempo again controlled the speed of movement.

Other musical activities relate to current happenings in the classroom including holiday songs. Many songs and rhythmic movements were included for the enjoyment of musical patterns and appreciation of mood. Music as a background was felt to influence the children's behavior. Some clinicians played instrumental records when the children arrived and departed. Children could choose to listen to music at certain times through earphones or free field.

Some clinicians did a lot of singing throughout the day. Children enjoyed being serenaded. It was always a super communicative experience to "sing" a question to a child and the child "sing" the spontaneous response. Children were encouraged to offer songs and to move in response to music.

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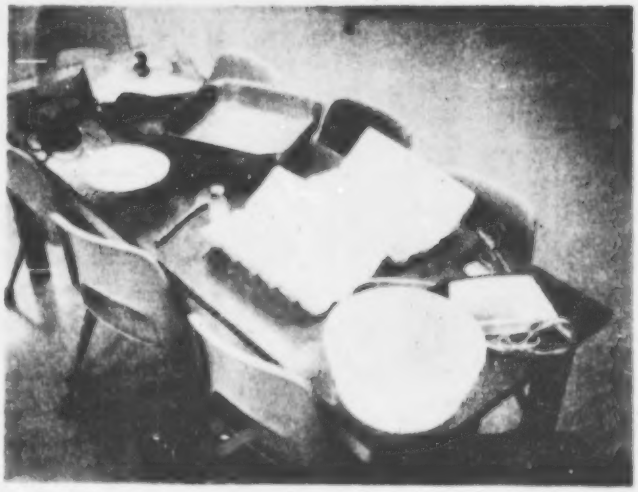
CHART #4

COOKING AS A LANGUAGE EXPERIENCE

I. Verbal Expression

- A. Spontaneous verbalization results from excitement and interest in cooking.
- B. Process of cooking provides exposure and meaningful use of new words and concepts.
- C. Process of cooking provides model for use of conventional sentence structure.



II. Sensory Experiences

- A. Taste.
- B. Smell.
- C. See.
- D. Feel.
- E. Hear.

III. Perceptual Motor Activities(Hand-eye coordination)

IV. Sequencing Activities

- A. Following directions.
  1. Safety(common sense).
  2. Order is important to get desired results.
- B. Observing physical changes.
  1. After performing certain operations(mixing, baking, etc.).
  2. After a period of time.

V. Mathematical Activities

- A. Counting.
- B. Fractions.
- C. Volume.
  1. Measuring.
  2. Containers.

VI. Problem Solving("What would happen if..?)

VII. Socialization Experiences

- A. Children accomplish something real & rewarding (eat the results).
- B. Importance of cooperation is learned-taking turns.
- C. Cleaning up is everyone's responsibility.

VIII. Nutrition

- A. Learn which foods are "good for you."
- B. Encourage good eating habits.
- C. Try new foods.

IX. Related Activities

- A. Art
- B. Stories
- C. Observe other physical changes in materials.
- D. Polaroid pictures of sequence of activities.

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SAMPLE COOKING ACTIVITY - SCRAMBLED EGGS

Language Concepts
1. Verbal Expression
2. Sensory experiences
3. Perceptual motor
4. Sequential
5. Mathematical
6. Problem solving
7. Social
8. Nutrition
9. Related activities

Eggs were chosen because they happened to be on sale. Cost is an important factor in selecting the food to be prepared. To provide funds, parents are assessed four dollars a semester which also includes milk several times a week. There are 16 children in the class.

Scrambling the eggs was attempted in order to provide each child with the experience of breaking an egg. (1,3, 5- numbers refer to language concepts listed to the side.) Even though many of the children have difficulty with perceptual motor tasks, they were surprisingly good at cracking eggs. They had some help in that the bowl was pushed under the cracked egg, so most of every egg landed in the bowl. During this operation we talked about the color of the egg inside and out, the texture (shell is hard; egg is soupy), the sound of the egg breaking, etc. (1, 2).

The eggs were beaten with an electric mixer. Each child held the mixer for a short time (3, 7). We talked about the sound of the different motor speeds. (The children liked the "fastest" sound.) We commented on how the eggs looked different. ("What happened to the yolks?") Milk was added and the color became lighter. (1, 2, 4)

Margarine was melted in the hot frying pan and the egg mixture was added. (1, 4) The children took turns stirring. (3, 7) They were aware of the hot pan. ("What will happen if you touch the pan?") (1, 4, 6) When the eggs were finished, we discussed how they changed. ("Now they're firm; before they were soupy.") and why ("because we cooked them"). (1, 2, 4, 6)

All the children ate their portion with apparent relish (8). They were shown polaroid pictures of the process. We discussed what happened first, second, etc. and who participated (1, 4, 7, 9). These pictures were used on succeeding days for sequencing temporal and linguistic events. Children are taught to sequence pictures from left to right.

Ingredients

1 egg per child
Milk (approx. 1 tbl. per egg)
Margarine
Salt

Equipment

Bowl
Beater or mixer
Frying pan
Wooden spoon

Vocabulary

shell egg white
yolk crack
beat done
soupy firm

PROFESSIONAL STAFF

This program was implemented by the Speech & Language Disabilities Department of Joint School District #10, Appleton, Wisconsin. One speech clinician served as teacher, programmer and team leader. The speech clinicians on our staff raised their levels of sophistication in the area of language development by reading (See bibliography for professional library suggestion) and by course work. Areas of interest included language development, language therapy, child development and behavior modification. Ideally the professional staff member would have a masters degree in communicative disorders with a concentration in language. The professional must be trained in speech and language assessment and differential diagnosis and in programming for speech and language development.

In addition to academic training the speech clinician in charge of a self-contained Oral Communication Center should have the following characteristics:

(1) Enjoys working with very young children.

(2) Ability to formulate long range goals and to see the whole child as well as his specific educational needs.

(3) Ability to formulate short range goals, specific goals for one ten minute session ie. task analysis.

(4) Ability to formulate lesson plans and procedures for an aide.

(5) Ability to create a center which is a learning environment in which the individual child's needs are met.

(6) Ability to work as a team member in the classroom and in the school system. Seeking out fellow professional's opinions and help.

(7) Ability to work with parents in a consultative capacity and to be realistic and reassuring.

(8) Ability to be flexible, spontaneous, confident and curious.

It has been our experience that once a speech clinician has conducted a half day self-contained program, he is sold on it as an efficacious system for delivery of service. Working as a classroom teacher-clinician half days and dealing with children for longer periods of time has broadened the clinicians concept of his role and function within a school. This expanded role of the speech clinician has directly altered fellow educators' attitudes in a positive direction and has, in the writers opinion, resulted in more and better services.....the taxpayers get more for their money by utilizing more fully the expertise of the speech clinician.

PARAPROFESSIONALS

Each class, called an Oral Communication Class, was staffed by a school speech clinician and one or two paraprofessionals. Practicum students in communicative disorders also participated. Placement of a practice teacher in this self-contained situation constituted half of the student teaching experience. The other half day was spent doing more traditional speech & language therapy.

Paraprofessionals (aides) were chosen using several criteria. A love of young children and a desire to help were two major criterions. We chose aides who were judged to be good communicators and flexible people. Some of our aides had their bachelor degrees (Communicative Disorders, Social Work, Elem. Ed.). One person (B.A. Communicative Disorders) took an aide's job in this program for the clinical experience.

She was an outstanding aide. However, we had excellent aides who held no degrees, or had no college training. Skills such as music and artistic skills were thought to be desirable. Predictions of ability to work as a team member and to be a realistic observer were also found to be valuable assets. Another judgment concerned the person's attitude toward "work", as there are many mundane chores. We found a good aide was aware of the individual child; his needs and his opinions.

Various interview methods were used. The first aides interviewed were given a chance to interrelate with young children. We happened to be having small groups of children in for selection purposes. The aide candidate was asked to help an individual child or to record one child's speech verbatim or to be helpful and serve juice, etc. This was felt to be a valuable part of the interview procedure. Certainly seeing a candidate interacting with children was revealing and it was interesting that one prospective aide didn't feel she wanted to pursue the job application after her "visit". Some aides worked all day long (switching schools at noon). This was found to be too fatiguing. The responsibilities of the aides were:

(1) To communicate with individual and small groups of children.

(2) To carry out a specified teaching assignment.

(3) To prepare materials.

(4) To record observations of childrens behavior in their logs.

(5) To do housekeeping tasks.

(6) To work as a team member.

In-service for aides was predominantly discussion of children's behaviors and program philosophies and procedures. An hour of planning time between 8:00 to 9:00 a.m. enabled us to hold discussions before the children came. Usually making notes in logs was done immediately after class dismissal.

Topics discussed included:

(1) Speech and Language Development.
   a. Sequence of learning.
   b. Components of language.
   c. Interrelationships with other modalities.
(2) Behavior Modification.
   a. Reinforcing desirable behaviors.
   b. Discipline.
(3) Auditory Environment Control.
(4) Aides role in language stimulation.
(5) Reinforcement of positive self-concept--eliminate failure.
(6) Encouraging child's independence--(helping the child help himself).
(7) Sequence of skills (ie. learning to assess where child is and why failure occurred--identify needed prerequisite skills).

In addition to discussions with, and formal presentation by the speech clinician in charge of the center, books such as Teach Your Child To Talk were available. Video tapes of youngsters were viewed and assessed. The role of video tapes in in-service training was not investigated fully. It is felt to hold much promise.

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HOUSING

The oral communications program was conducted in a full sized classroom, usually a kindergarten room in an elementary school. It is necessary to have toilet facilities close by, preferably in the room. A sink in the room is helpful. In situations where these minimum requirements were not met, the program was curtailed because of lack of space or wasted time. The gymnasium and audio-visual materials center were also utilized. The building principal was extremely important in facilitating housing, scheduling and materials.

The room was equipped with several tables and chairs of suitable size. Four foot dividers (chalkboard, pegboard), shelving and furniture served to divide the room into several study areas. A large space for group meeting and activities was maintained.

Toys such as blocks, trucks, airports, puzzles, manipulative and fit-together toys, manipulative learning materials, puppets, climbing triangles, trains as well as scaled down furniture were in the classroom. Equipment such as balls, cones, scooter boards, scoops etc. was usually available in the gym. Many objects from everyday life such as tires, cardboard boxes, sand, water and containers were found most useful.

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Audiovisual Equipment

This educational program has been greatly enhanced by the use of audio-visual equipment. Photographs, slides, audio and video tapes allow the educational leader to provide the necessary auditory stimulation. We have found that use of audio-visual equipment not only is motivating but affords the opportunity to relive experiences and to provide necessary redundancy. The purpose of using the audio-visual equipment described in this section is to help children become auditorially and visually aware of themselves and others. It provides the opportunity to make programs based on the first-hand experiences of the children. We selected all equipment with the thought in mind that we wanted to have the flexibility to put our own verbiage with our own pictures. As an example, this procedure allowed us to take a series of slides (from a field trip) and to make several sound tracks; each relevant to children at different levels of language competence. Frequent use of audio-visual equipment and proper training in its operation (both by the clinician and the children) provided good results. We were fortunate in having an audio-visual specialist from our district to consult. He acquainted us with the wide range of available equipment and advised us on purchase taking into account the life span, service, fidelity and flexibility of the equipment. The equipment we used is discussed below along with a priority rating and suggestions for use with young children.

POLAROID CAMERA

A polaroid camera provides instantaneous capture of events. It is one of the most valuable pieces of equipment. It was operated by adults. We purchased the model that does not require flashbulbs in the classroom. It was found useful in:

1. Self-identification and reinforcement of positive self attitude.
2. Identification of classmates--used for roll call, task assignments, etc.
3. Sequencing language events--put pictures in temporal order.
4. Reliving experiences--"books" made of events.
5. Observing visual detail.

Some disadvantages are that the size of the picture is relatively small, and that there is no negative to have individual reprints. One can photograph polaroid pictures on a half frame camera to make a filmstrip (or a slide). The advantages outweigh the disadvantages by far. Young children who were unable to identify themselves in photos were aided in doing so because of the instantaneous result.

VIDEOTAPE

We used a half inch portable videotape. Classroom lighting was sufficient. The feature of having sight, movement and sound simultaneously was thought to be most valuable. Videotapes were found useful in:

1. Recording classroom events.
2. Reliving events; classroom activities, resource people, pets, field trips.
3. Describing activities through the use of the audio dub or live clinician describing activity being taped.
4. Aiding child in self-identification (saw and heard self from all angles).
5. Helping children become auditorially and visually aware.
6. Making longitudinal case histories.
7. Parent training, ie. observing parent-child communication and behaviors as well as showing parents how child functioned in classroom.

A videotape recorder is as easy to operate as a tape recorder. A battery lasts half an hour and it is rechargeable. The portable machine does not afford simultaneous recording and viewing. Videotape is reusable. The portable equipment is relatively heavy, and we found that we used it in school (on a cart with the camera on wheels) more often than on field trips. Like all equipment the more we operated it the more efficient we became. Young children who had shown very little interest in T.V. viewing began to see relevance between T.V. and their own experiences.

SOUND-ON-SLIDE RECORDER-PROJECTOR

This piece of equipment has the advantage of having the slide and the grooved magnetic tape on one cartridge. Thus the verbiage is always synchronized with the picture. It advances automatically or can be manually operated. The children operated it easily and learned quickly that they had to push the button twice. Voice fidelity is very good as is environmental and background sound. The recorder and projector are contained within the one unit. We found it best to put the slides in the desired sequence, write the script and then record. Cartridges can be rearranged in sequence. One tray of slides then has one sound track. The sound-on-slide was useful in:

1. Providing auditory stimulation, ie. language exemplars.
2. Providing visual and auditory experiences related to reliving and/or recalling firsthand experiences.
3. Preparing children for field trips.
4. Providing audio-visual aids for public speaking, in-service, etc.
5. Providing an opportunity for children to share their slides from home.
6. Bringing environmental sounds into the classroom.

SLIDE PROJECTOR COUPLED WITH AUTOMATIC CASSETTE TAPE RECORDER

Coupling a slide projector with an automatic tape recorder results in a sound with slide presentation. The uses are the same as the sound-on-slide discussed in the preceding paragraph. This is a more economical arrangement. The disadvantage being that an adult must initiate the presentation to insure that the sound and slide are synchronized. This coupled arrangement is used only on automatic advance. We made several sound tracks for a slide tray emphasizing various language forms or vocabulary items. Care must be taken to see that the picture and sound are synchronized.

SLIDE PROJECTOR

Young children learned quickly how to advance slides. We felt that one little fellow understood "focus" before other conventional words. The size of the image caused various responses in children. One boy said, "me baby", when viewing himself but changed to, "now me big" when the projected image was larger. Use of a slide projector enables:

1. Children to narrate and present.
2. Clinicians to describe, recall and/or prepare children.
3. Children to have experience in visual discrimination tasks.
4. Children to imitate body positions, facial expressions, etc.
5. Discussion of picture.

RECORD PLAYER

Record players were used a great deal in music and movement education. Usually the words on records are too rapid and too numerous to use them in teaching songs. Holiday songs, background music, relaxation music and sound effects were played. Children enjoyed sharing records from home. One little fellow listened to music every chance he got. It was one of the listening choices available.

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SOUND WITH FILMSTRIP (Audotmatic advance)

We use two types of sound with filmstrip projectors. One projects the image on a small screen; one on a large screen. Care must be taken to synchronize the picture and the sound. Sound with filmstrip can be utilized in many of the same ways as previously discussed in this section. The recorder-pulser is a separate piece of equipment. It records the audio signal and the automatic advance pulse. Film strips from our school libraries were used. Traditional fairy tales as well as life related filmstrips were narrated appropriately.

CAMERAS

A camera which takes clear photographs(slides and prints) is felt essential in making meaningful audio-visual programs based on first hand experiences.

We used 35 mm cameras with automatic strobe to eliminate the need for flashbulbs. Slides and prints were used as discussed. Young children's expressive speech was motivated and enhanced through sending home photos of classmates, special happenings, etc. The picture of Terry after he fell in the mud, was a favorite choice of the children to take home. Processing was usually completed on slides and prints within 24 hours (commercially). We felt it necessary to use the pictures soon after they were taken and the children never tired of seeing them repeatedly.

It is possible for us to make filmstrips from our slides and prints by using a half-frame camera. This requires more technical expertise. Our audio-visual specialist operated this camera. It is expensive and once the filmstrip is made you cannot rearrange the pictures. There are commercial services of this nature also.

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TAPE RECORDERS

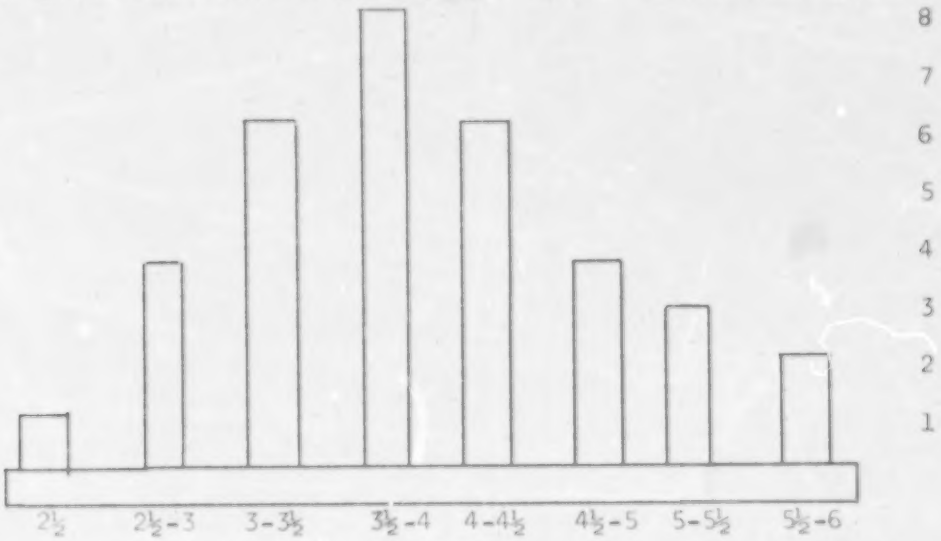
Cassette tape recorders with built in microphones were portable, sturdy and easily operated by the children. These features added to their utility in recording sounds of experiences, environmental sounds, voices, etc. We suggest purchase of a cassette tape recorder with a pulser enabling use with a slide projector which will then advance automatically. Reel to reel tape recorders were used in the classroom because the voice quality was felt to be of higher quality. Tape recorders aided children in: Remembering sounds, associating sounds and sequencing sounds. Also, tape recorders were used to make phonetic transcriptions of a child's speech. Some parents recorded the speech of the child at home to aid in differential diagnosis and program planning.

We were continually amazed at the children's attention to auditory and visual events when audio-visual equipment was used with meaningful verbiage. Children learned to operate certain of the machines. It was interesting to see that children attended longer, as a rule, if they could advance the picture manually. Pushing the button seems rewarding. When programs were automated they were ordinarily kept to ten minutes or less. The major equipment used has been discussed. A listening center in each oral communication center (each classroom) is a must.

Reliving creative drama:
"The Lion Who Lost His Tail..."
through Sound on Slide.

Evaluation

First year evaluation procedures included analysis of tape and video recordings, daily logs and parent interviews. Chart #5 and Chart #6 summarize the progress in expressive speech over the school year. The morning group of 22 children had greater language facility than the group of 12 children who came in the afternoon. Age range for the entire group of 29 boys and five girls was from two years, five months to six years, one month.



Parents were interviewed by a social worker and their responses indicated that they felt the children behaved in the following manner because of the program:

1. Talked more.
2. Were more independent.
3. Were better able to help themselves in activities of daily living.
4. Followed directions better.
5. Were more attentive.
6. Were more inquisitive.
7. Were more aware of their total environment.
8. Played more successfully with peers.
9. Were easier to live with.
10. Were favorably disposed toward coming to school.
11. Had a better sense of humor.

Evaluation procedures of five Oral Communication Classes during the 1972-1973 school year consisted of extensive pre and post language tests. Table 1 summarizes group gains on the auditory-vocal subtest of the Illinois Test of Psycholinguistic Abilities and on the Peabody Picture Vocabulary Test. All groups made significant gains in verbal expression. The same held true for single word comprehension (PPVT) and Auditory Association with the exception of Group 4. It is interesting to speculate on the relative gains of this group because this group consisted mainly of children who were enrolled in the program the previous year. In other words this evaluation year ('72-73) was their second year in the program. Group gains on the PPVT had been significant the first year. Included in the program, but not in the statistical analysis, were children who did not respond to the tests in September. Therefore test scores were not available for comparison. In looking at net change

CHART # 5

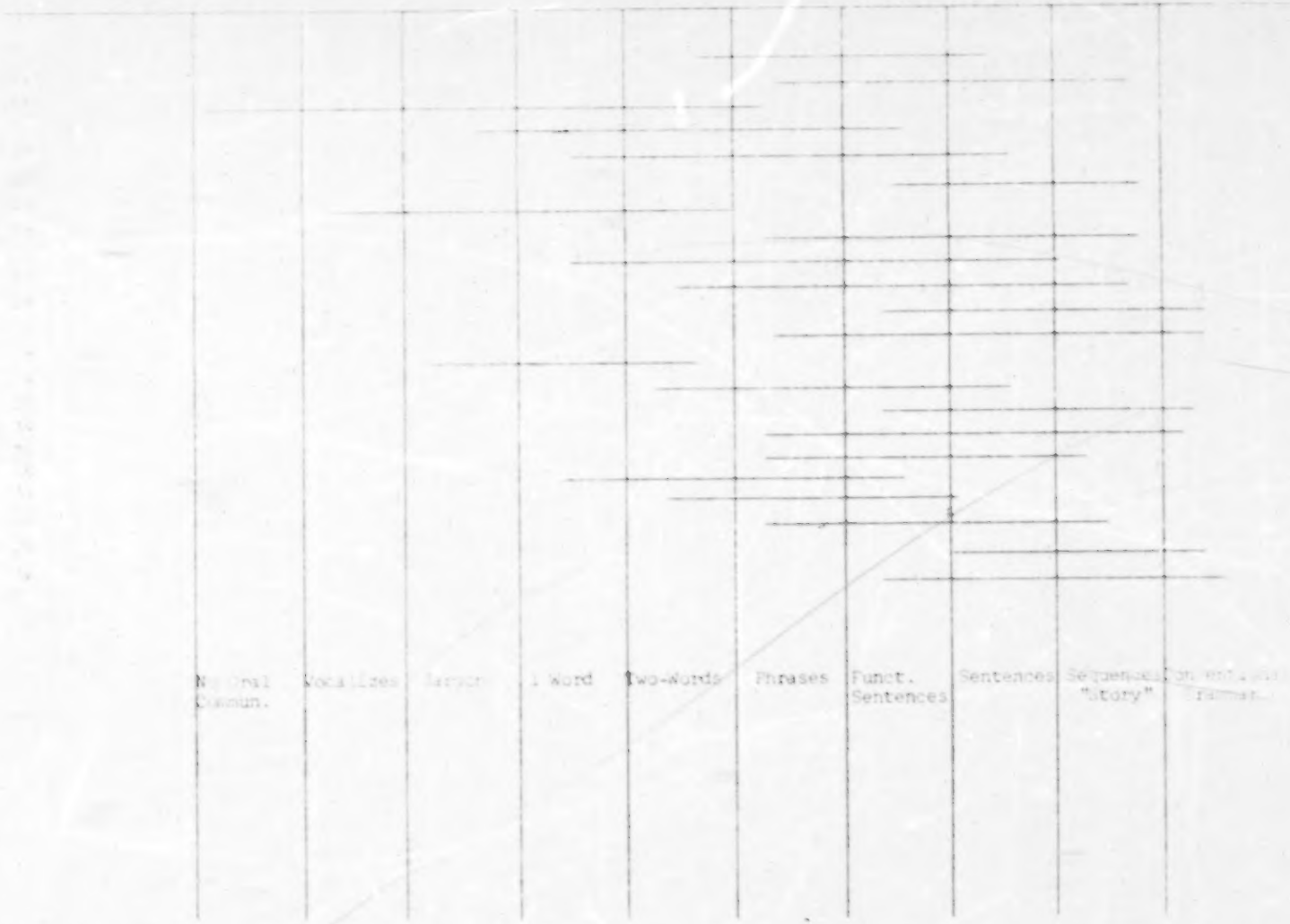
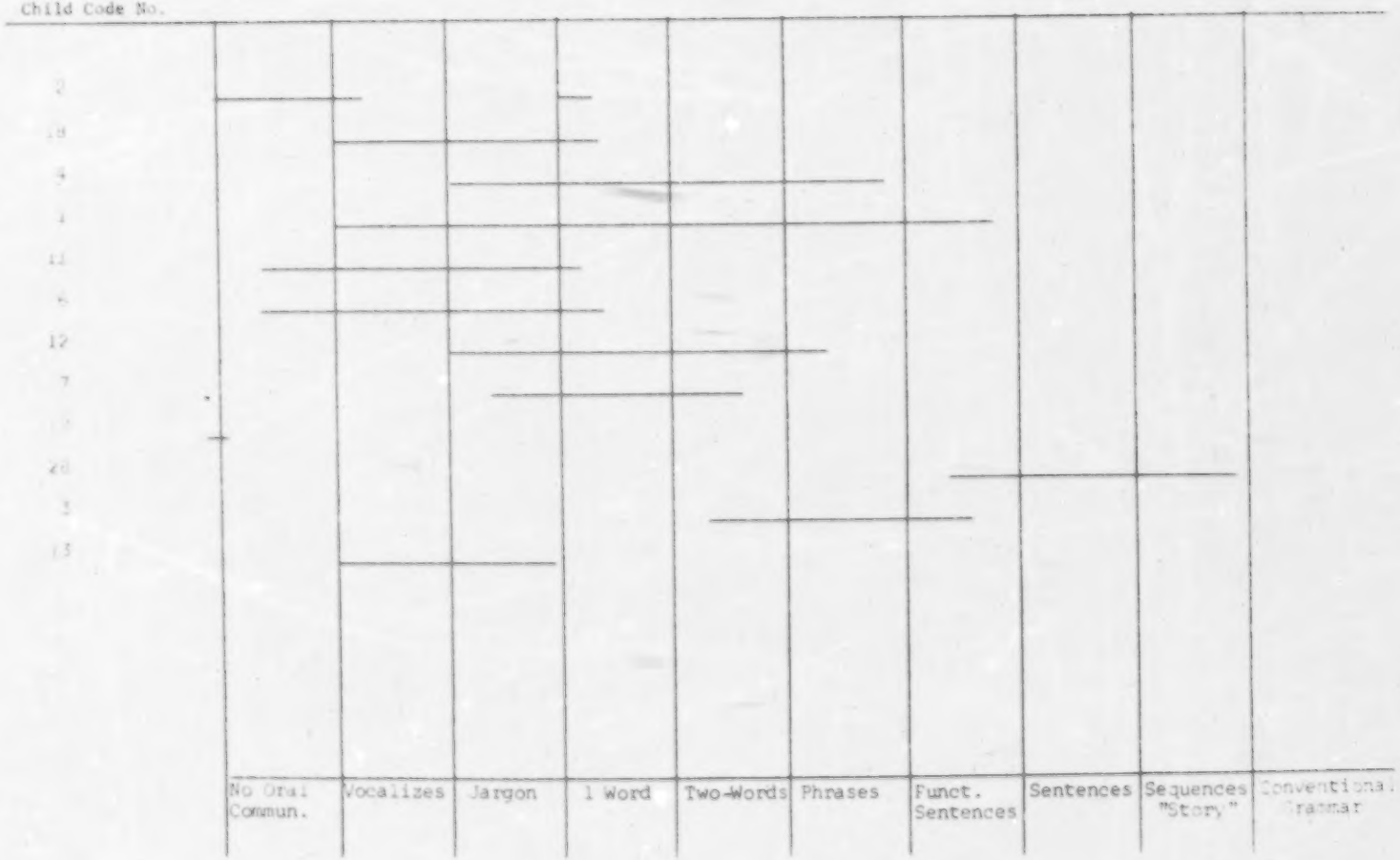


CHART # 6

Pre-Academic Oral Communication Center - Language Progress During School Year

1971-72 School Year

Afternoon Group



there were no absolute regressions, there were seven group gains which were less than predicted for normal children and there were 38 gains which signified a closing in the gap between language age and chronological age. Increased verbal aggressiveness and increased attention to auditory events were evidences of these significant language gains in the everyday lives of the children.

Table 1

Summary of Group Gains on Five ITPA Subtests and the PPVT.

Name of test	Loss	Gains < maturation	Gains > maturation	LA=CA
Aud. Reception		3, 5	1, 2, 4	
Aud. Association		4	1, 2, 3, 5	
Seq. Memory		2, 5	1, 3, 4	
Verbal Expres.			4, 5	1,2,3
Gram. Closure		3	1, 2, 4, 5	
Picture Vocab.		4	1	2,3,5

Description of groups:

Groups 1 through 5: Half day pre-academic classes taught by speech and language therapists. Some of the students were in kindergarten for an additional half day.

1. Washington School
2. Highlands School (not multiply handicapped)
3. McKinley School
4. Johnston School
5. Huntley School

roup 1 Average Age 5 years, 0 month

TEST	September Disc.(1)	S.D.(2)	June Disc.(1)	S.D.	Summary N(3)	Net Change	t(4)
ITPA Aud. Rec. (a)	- 8.7	12.4	- 7.4	9.4	11	1.4	0.37
ITPA Aud. Assoc. (b)	- 8.5	10.0	- 7.0	7.0	11	1.5	0.85
ITPA Seq. Memory (c)	-18.9	10.6	-15.6	18.8	11	3.3	0.85
ITPA Verbal Exp. (d)	-12.1	11.1	0.1	14.0	11	12.2	3.42*
ITPA Gram. Closure (e)	-11.5	14.6	- 9.5	14.4	10	2.0	0.51
Peabody Vocabulary (f)	- 6.4	10.0	- 2.6	11.1	10	3.8	6.36*
NSST Receptive (g)	RS 20.8 %ile-10th	6.9	RS 26.2 %ile-25th	5.3	10	5.4	7.10*
NSST Expressive (h)	RS 10.3 %ile-10th	6.8	RS 10.3 %ile-10th	10.3	9	14.4	2.25*
Boehm Basic Concepts (i)	15	15	20	1.5	10	5	5.84*

*Significant at .10 level using two-tailed test.

Group 2 Average Age 5 years, 2 months

TEST	September Disc.(1)	S.D.(2)	June Disc.(1)	S.D.	Summary N(3)	Net Change	t(4)
ITPA Aud. Rec. (a)	-13.0	10.8	- 9.3	9.3	16	3.7	1.37*
ITPA Aud. Assoc. (b)	- 9.8	7.4	- 4.1	2.5	16	5.7	3.49*
ITPA Seq. Memory (c)	- 8.2	5.8	- 9.1	5.4	13	- 0.9	0.27
ITPA Verbal Exp. (d)	-11.8	3.3	4.5	3.3	14	16.3	4.81*
ITPA Gram. Closure (e)	-12.5	9.8	- 5.9	6.8	15	6.6	3.01*
Peabody Vocabulary (f)	-13.2	11.5	0.5	10.0	15	13.7	5.17*
NSST Receptive (g)	RS 17.4 %ile-10th	5.6	RS 13.8 %ile-10th	7.3	5	2.2	1.41
NSST Expressive (h)	RS 17.6 %ile-10th	4.6	RS 22.3 %ile-10th	6.5	9	10.7	7.12*
Boehm Basic Concepts (i)	14.4	5.4	27.2	6.9	13	11.8	5.72*

*Significant at the .10 level using a two-tailed test.

Group 3 Average Age 5 years, 6 months

TEST	September Disc.(1)	S.D.(2)	June Disc.(1)	S.D.	Summary N(3)	Net Change	t(4)
ITPA Aud. Rec. (a)	-10.2	14.8	-12.2	8.0	14	- 2.0	0.45
ITPA Aud. Assoc. (b)	-10.4	6.5	- 7.7	8.0	14	2.7	1.43
ITPA Seq. Memory (c)	-16.7	14.9	-12.3	19.9	14	4.4	1.17
ITPA Verbal Exp. (d)	-17.3	7.4	+11.9	13.0	13	29.2	8.37*
ITPA Gram. Closure (e)	-11.3	12.9	-13.6	13.1	14	- 2.3	1.19
Peabody Vocabulary (f)	- 5.5	9.8	+ 0.5	8.8	14	5.8	1.44
NSST Receptive (g)	RS 16.4 %ile-10th	5.7	RS 18.9 %ile-10th	5.8	14	1.8	2.35*
NSST Expressive (h)	RS 6.1 %ile-10th	1.6	RS 12.9 %ile-10th	1.6	10	6.8	5.86*
Boehm Basic Concepts (i)	17.8	3.4	22.1	1.4	13	4.3	3.78*

*Significant at the .10 level on a two-tailed test.

Group 4 — Average Age 4 years, 9 months

TEST	September Disc.(1)	S.D.(2)	June Disc.(1)	S.D.	Summary N(3)	Net Change	t(4)
ITPA Aud. Rec. (a)	-12.6	14.1	-10.3	10.2	11	2.3	0.85
ITPA Aud. Assoc. (b)	- 8.8	11.5	- 9.0	12.7	11	-0.2	0.10
ITPA Seq. Memory (c)	- 9.9	11.5	- 8.6	9.3	10	1.3	0.70
ITPA Verbal Exp. (d)	-18.0	12.3	- 9.0	11.6	10	9.0	5.29*
ITPA Gram. Closure (e)	-15.3	16.1	-14.2	19.0	10	1.1	0.50
Peabody Vocabulary (f)	- 5.2	14.1	- 5.4	16.0	12	-0.2	0.06
NSST Receptive (g)	RS 18.3 %ile-10th	6.8	RS 26.9 %ile-25th	10.8	11	8.6	4.57*
NSST Expressive (h)	RS 9.8 %ile-10th	5.7	RS 17.2 %ile-10th	9.6	10	7.4	4.72*
Boehm Basic Concepts(i)	15.1	6.2	17.5	5.2	11	2.4	3.69*

*Significant at .10 level using two-tailed test.

Group 5 — Average Age 5 years, 6 months

TEST	September Disc.(1)	S.D.(2)	June Disc.(1)	S.D.	Summary N(3)	Net Change	t(4)
ITPA Aud. Rec. (a)	- 5.9	10.8	- 7.8	12.6	10	-1.9	0.57
ITPA Aud. Assoc. (b)	-18.6	18.3	- 9.0	6.6	10	+9.6	1.67
ITPA Seq. Memory (c)	-16.1	16.2	-16.7	9.5	10	-0.6	0.12
ITPA Verbal Exp. (d)	-17.3	15.9	- 8.4	14.2	10	8.9	1.86*
ITPA Gram. Closure (e)	-12.9	17.4	-10.4	11.2	10	2.5	0.60
Peabody Vocabulary (f)	- 8.8	17.8	+ 5.9	12.8	10	14.7	4.42*
NSST Receptive (g)	RS 16.6 %ile-10th	4.2	RS 19.8 %ile-10th	2.6	10	3.2	2.30*
NSST Expressive (h)	RS 12.2 %ile-10th	4.9	RS 18.1 %ile-10th	3.8	9	5.9	6.31*
Boehm Basic Concepts(i)	19.2	4.8	20.9	2.9	9	1.7	2.23*

*Significant at the .10 level using a two-tailed test.

Illinois Test of Psycholinguistic Abilities
Subtests (a) Auditory Reception
(b) Auditory Association
(c) Sequential Memory
(d) Verbal Expression
(e) Grammatic Closure

(f) Peabody Picture Vocabulary Test
Northwestern Syntax Screening Test
(g) Receptive skills
(h) Expressive skills
(i) Boehm Basic Concepts Inventory

(1) Discrepancy between chronological age and language age score in months at time of testing.
(2) Standard deviation of scores.
(3) Number of students having both pre and post test scores.
(4) Change in discrepancy between C.A. and L.A. in months.
R.S. Raw scores only are available for this instrument.

INTERPRETATION: Net changes have already been corrected for maturation.
-8 or lower: post test score is lower than pretest; absolute regression.
-8 to 0: gains are less than predicted for normal children; absolute growth but continuing to fall behind non-handicapped peers.
0 or higher: gains equal or exceed norms for non-handicapped children; closing gap between language age and chronological age.

INDIVIDUAL CASE REPORT - DONALD

I. Description of the Child

Donny is a five year eleven month old boy of average height and weight. He was referred at the age of three years one month to the Speech & Language Disabilities Department with the complaint that he was not able to communicate orally and that he stuttered. The mother was concerned because he was producing only a few isolated words. His father and his grandmother thought that Donny was retarded, but his mother didn't think so. A language and learning assessment revealed a severe deficit in oral communication and specific deficits in some areas of learning. It was on this basis that he was enrolled in a pre-academic oral communications class. Donny has been involved in the program for three years and has shown remarkable gains in all areas of development.

II. Initial Observations

Donny would not separate from his mother in the testing situation, therefore, he was seen with her. His mother related that he had been afraid to be left alone since a hospital stay at the age of two years. He was generally quiet and unresponsive but he did say a few single words such as "chooh, chooh" and a few two word strings such as "water, momma do". The Peabody Picture Vocabulary Test was given but it was thought to be unreliable because Donald guessed a great deal and responded somewhat to his mother's facial expressions. His hearing was felt to be within normal limits bilaterally. Donny's general coordination was felt to be good and he preferred to do self-help things by himself. He could feed and dress himself. He could entertain himself very easily with simple objects and usually chose to play by himself. He did not associate with other children. He was not openly hostile but ignored their presence for the most part.

Donny had a very poor self-image. According to his mother, he needed frequent reassurance that he was loved. Donny is the youngest of four children. His mother felt that the relationship between the children was good, although the other children liked to "aggrvate" Donald. Mother also stated that Donald "can be very hard to handle" and "bullheaded". When she was asked what measures she found most effective in disciplining Donny, she stated, "Tell him naughty boys do that and I don't love naughty boys, try to get him to say he is sorry".

III. Therapy Plan

Donny was enrolled in a half day program five days a week. The goals of the program were to increase his communication skills and to build a positive self concept.

The first step in increasing Donny's communication skills was to create an environment which would free him from the fear of failure and stimulate a desire to talk. He was allowed to choose those activities which he enjoyed and was successful at. For the most part, he followed the clinician around and tried activities only when the clinician suggested them. Within a few weeks he was playing much more independently. He responded when he was called upon and generally tried to do what was asked of him. Once Donny's image of himself as a

communicator had improved, therapy was centered around developing some auditory perceptual skills, developing basic concepts, (especially those regarding space and quantity) and vocabulary building. This year, his third year in the program, Donny has been enrolled in ½ day kindergarten and ½ day oral communications. There has been special emphasis placed upon auditory discrimination skills and following directions. The clinician has tried to correlate some of the therapy activities with those activities that are going on in the kindergarten classroom in an effort to make Donny's kindergarten experience successful and rewarding for him.

Absolutely vital in increasing Donny's communication skills and building a positive self concept was extensive parent training and counseling. Donny's parents were "hung up" on discipline. They either tried to scare him into behaving with stories of "boogie men" etc. or they tried reasoning types of things in a effort to get him to discipline himself. It was suggested that they use behavior modificiation techniques....not withholding love and affection when he was bad but rewarding him when he was good.

When Donny's mother brought him in for an evaluation, it was suggested that possibly his parents were not communicating with him on his own level. In an effort to point this out, the clinician videotaped a conversation between Donny and his mother. His mother then watched herself on tape and was surprised to see that she was not only speaking above his level of comprehension but that she also "didn't even answer his questions". The clinician then began working with the mother, teaching her how to talk to Donny, how to comment upon things around him, and how to ask questions that would increase his vocal language skills. The clinician observed other mother-child conversations and pointed out various techniques that could be used to stimulate speech from Donny. For example, it was noted that often Donny's mother was not looking at him when she was talking to him. By improving eye contact when she was speaking to him, she was able to increase his attention and a positive view of himself as a communicator. The clinician also suggested books, which the mother took, on how to talk to him. The success of the parent training is well evidence by the progress Donny has made over the last three years.

IV. Progress Indicated

EXPRESSIVE LANGUAGE SKILLS:

Prior to enrolling in the Oral Communications Program in September of 1971, Donny was quiet and unresponsive and his expressive speech consisted of a few isolated words. By December of 1971 he was naming some shapes and colors as well as rote counting to four. He was stringing two and three words together and verbalizing much more.

By the end of his first year in "speech school" Donny was verbalizing much more freely and when he was fluent, his conversational speech was intelligible. Results of an articulation test indicated some articulation errors (/s/ in the initial position and substitutions t/d, w/r). His sentence structure was syntactically correct. On the verbal expression subtest of the I.T.P.A. Donny's language age coincided with his chronological age. On the grammatic closure subtest his language was 3 years 10 months. His chronological age was 4 years 2 months.

In June of 1973 following his second year in "speech school," Donald's sentence structure was conventional for his age. He was using plurals, possessives, contractions, and the past tense in spontaneous speech. He still had some articulation errors (/s/ produced inconsistently). His dysfluency was diminishing.

Now at the end of his third year, Donald expresses his ideas freely in a group situation. He is able to describe in detail and sequence the events of the day. He participates and takes part in "class plays" and puppet shows. He scored one year above his chronological age in verbal expression and one year eleven months above his chronological age in grammatic closure. His articulation errors have been corrected and he has occasional periods of dysfluency.

RECEPTIVE LANGUAGE SKILLS

In the fall of 1971 prior to enrollment Donald showed a discrepancy of 19 months on the Peabody Picture Vocabulary Test and he did not respond to verbal directions. In February of 1972 Donald was only one month below his chronological age on the PPVT and could understand most basic concepts. Words concerning space and quantity were not comprehended. He was following simple two part directions.

In the fall of 1972, at the start of his second year, Donny's receptive abilities appeared to be significantly better than his expressive ability. He scored one year one month above his chronological age. He also scored at levels above his chronological age on the auditory reception subtest and the auditory association subtest of the ITPA.

In June of 1973 following his second year, Donald's vocabulary of understanding and expression was very good. On a test of single word comprehension, he scored nine months above his chronological age. He could recall two and three part directions in the correct sequence.

At the end of his third year, Donny's receptive vocabulary is one year three months above his age level. He responds well to complicated verbal directions. He enjoys listening to records and storybooks and he is able to retell a story in conventional sequential order without benefit of visual stimulation. He enjoys and is very clever at figuring out riddles.

OTHER SKILLS

When Donny was first enrolled in the program, his levels of physical coordination and gross motor skills were subnormal for his age. Donald was a very distractible child and at times had difficulty focusing his attention. His self-help skills were good but he was lacking in social skills and had a very poor self-image.

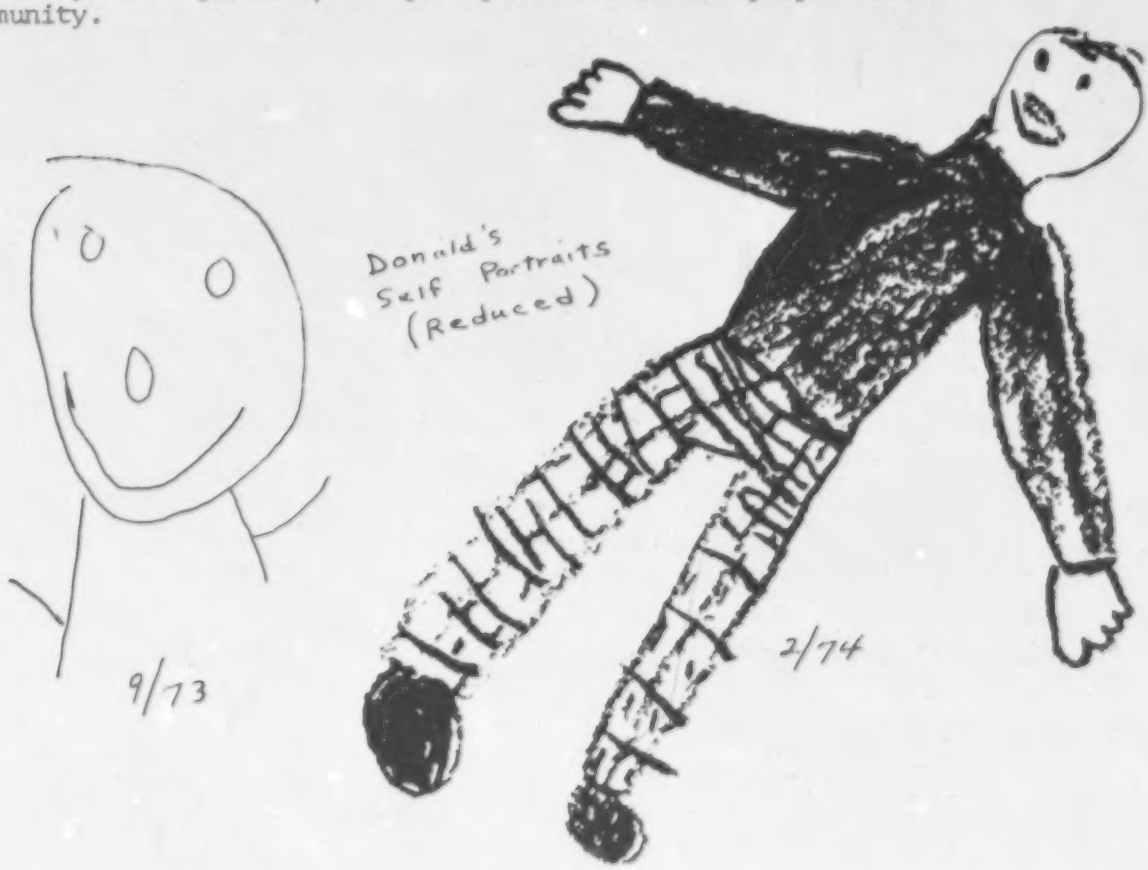
At the end of the 1971-72 school year Donny was improved in social skills, although he frequently played by himself, he would play well with one neighborhood boy and with the other children in the class. His self-help skills remained above his age level. His attention span had improved. He could maintain a longer attention span for a specific task, although he continued to be intermittently distracted by his environment or by his own train of thought. His physical skills were still quite immature. His self-image was still poor but had improved.

At the end of the 1972-73 school year his attention span, self-help skills, and social skills were good for his age. His physical coordination and fine motor skills were improved but he still needed work on gross motor skills. His self-image was improving gradually as he was becoming more of an individual and standing up for himself.

At the end of his third year in school, Donny is functioning at or above age level in all areas. The most startling change has been that of his self-image. He has assumed a leadership role in the classroom and has learned to play well with other children. He responds similarly in the kindergarten room. Donny's drawing of himself of September 1973 shows the drawing of an average four year old and his picture of January 1974, Donny has jumped a number of years above his age level. He recognizes the written names of all the children in class and reads color and number words. He can do all addition combinations one to five. His sense of humor is well developed and fun.

V. Prognosis

Next year Donny will be placed in a regular first year primary classroom. He is at the conventional chronologic age placement. His kindergarten teacher and the speech & language clinicians who have been working with him feel that Donny will have no problems in that situation. The speech and language clinician will continue to be available as a resource person to aid the classroom teacher should any problems arise. His parents and grandparents now rate him as average to above average in intellectual potential. They, along with many other parents, are good public relations people in the community.



Epilogue

Looking back on this project, as we have set it down on the preceding pages, it almost seems that we were like "babes in the woods" when we began working on it four years ago. In fact, the idea underlying the project could be said to have germinated in the woods--the lush and fertile north woods of our State of Wisconsin. It was there, in an idyllic setting near Manitowish Waters, that two of our clinicians attended a week long workshop.

This workshop was sponsored by the Division for Handicapped Children of the Wisconsin State Department of Public Instruction. It was the result of the combined efforts of Mrs. Alverna Robinson and Mr. Vernon Smith. Together they brought to us the brilliant researcher, Dr. Paula Menyuk of MIT, and the outstanding educator and researcher from our own state, Dr. David Yoder, University of Wisconsin, Madison. Their presentation of language research and acquisition was erudite, yet easily understandable. Their burning desire for those of us in the field to take theories and facts and make them applicable to the realities of education kindled a flame of desire in those present.

Like the mythical Greek who carried the Olympic torch through the land our clinicians guarded and cherished this flame and on winged feet (well, actually, it was a plucky black Volkswagen) bore it back to us in east central Wisconsin.

Through them, a flame was ignited in all of us; and we began to consider, with trepidation at first, the possibility of fulfilling a new role in our dedication to the exceptional educational needs of children.

The flame certainly was often in danger of being extinguished in those first months. No one, among us, easily gives up security and tradition for the unknown and untried. It was all so much work at first. Everything seemed so unfamiliar.....the role, the terminology, the methods, everything. Many of us resisted at the outset and tried to remain in the comfortable role we had known for years, a role in which we felt competent and secure.

But the flame was there, and as moths are drawn to the light, we continued to turn toward the flame and each time we turned we became more enchanted and entranced by what we saw. Slowly at first, and then with increasing rapidity the flame lured us to its very center; and we were consumed with the desire to learn more, and to try more, and to experience more--until finally the flame enveloped us and we were all willing victims of its brightness and intensity. The more we learned, the more we ventured to apply our newfound knowledge. Naturally enough, the more we applied our knowledge the greater the fire became and soon it fed upon itself and then we knew we no longer cared for the darkness of our cubbyhole therapy rooms and the dreariness of articulation therapy.

We hasten to add that we have not completely forsaken articulation therapy. But where before, it was almost the sole weapon in our arsenal, it now became only one of many--and as such articulation therapy began to make a lot more sense. A child with multiple articulation errors is often a child with other related problems. As we followed these children through the primary levels, we found that they had academic problems, directly or indirectly related to their early inability to process in some area of auditory-vocal language.

At first some of us felt that we were satisfied with the status quo, and that not only were we satisfied but we thought that our school system and board of education were satisfied. Perhaps this was so; more likely it was our desire to resist change that made it seem so at the time. But when we began to think about the children we were hired to serve, our satisfaction palled. We asked ourselves if these children were happy, satisfied, well-adjusted members of their educational communities. We wondered if we really had made any serious impact on their educational future. We wondered if they truly were better, more capable students because we had taught them to say "rabbit" instead of "wabbit"?

For years we had worried about "carry-over", not realizing that carry-over could not take place in a clinical setting divorced from reality. Reality was what a child met when he stepped outside the doors of our isolated therapy rooms.

In the life-oriented approach, we have outlined in this paper, there was no need for carry-over. The child performed and spoke simultaneously about things he was actually experiencing and manipulating. Here we had carry-over, or carry-through, the way it was in real life, the way it should and must be, if it was to be relevant and lasting.

"Seat-of-the-pants" therapy is passe. Communication needs are out there "where the action is"--in the classroom, the street, the playground, the home, the barnyard, the park--or wherever you find children living and interacting. We have to be aware of these needs and be out there with the children, teaching them what they need to know so that they may function as "communicators."

For man is indeed a communicator, and he will devise a method or system of communication against almost overwhelming odds. All we are trying to do, is to make these odds a little less formidable for the child who, through some neurological, biological, or sociological quirk, has had the odds stacked against him from the beginning.

It is challenging, exciting, fulfilling, and often frustrating work. But the frustrations are caused not by the children, or by the program; but rather by our own lack of knowledge. There is so much as yet unknown in the fields of linguistics, psycholinguistics, and socio-linguistics. We must all join hands in experimenting and programming, and reporting successes (and failures too) so that we may learn from one another. Then and only then will our work become less frustrating. This project is so big and so complicated, that only a massive all-out assault is going to give us the answers we need to function more effectively.

We feel confident that our field has more than its share of creative people who can, if they will, pool their collective talents to come up with new and better methods of helping linguistically handicapped children. Therefore, we appeal to each of you to participate actively in early oral language intervention. There are so many children out there in all of our communities who are depending upon us. We will work harder than we have ever worked before. By the same token the rewards are far greater than the work involved; for if you give the child the gift of communication, you have given him his humanity.

We urge you to take the torch that we've managed to keep smouldering. Take it and apply to it the fire of your uniqueness and individual philosophies, and then bring it back to all of us, a thousand times brighter. Working together we can light new torches to shed new lights into this area of early language learning. Working alone we all will remain in darkness just that much longer. For the young language delayed child now being identified...."later" may not be soon enough. We cannot let him down!

JOINT SCHOOL DISTRICT NO. 10
CITY OF APPLETON ET AL
120 E. HARRIS STREET
APPLETON, WISCONSIN 54911
TELEPHONE: 739-3121

739-3121
Ext. 38

Spring 1971

Dear Parent:

Would you help spread the word about our pre-academic oral communication program?.....for young children delayed in speech and language skills. This program, for children ages 2 to 5, is designed to help improve talking and listening skills. Half day classes meet daily; there are several classrooms located throughout Appleton.

Parents are usually concerned about children who:

1) Are late to begin to talk.
2) Communicate very little with words.
3) Use gestures rather than words.
4) Speak in short phrases or immature sentences.
5) Follow oral directions poorly.
6) Attend poorly to stories read to them.
7) Do not seem to hear well.

Referrals of children may be made by calling 739-3121, Extension 38. Parents are given an appointment for a speech, hearing and language evaluation when they call. During this evaluation parents and speech clinicians confer about the child while the child is being observed by another speech clinician.

I welcome referrals. A limited number of children from our Appleton Public School district can be enrolled. Also, suggestions for home training are available.

Sincerely,

Grace M. School

(Miss) Grace M. School
Department Head
Speech & Language Disabilities

GMS/kms

Appendix B

BEST COPY AVAILABLE

WANTED

YOUNG CHILDREN

Appleton Public Schools

Pre-Academic

Oral Communications

Center

... fold...

LANGUAGE EXPERIENCES

SELF EXPRESSION

MEANINGFUL SITUATIONS

SOCIALIZATION

...fold...

ANNOUNCING

A NEW PROGRAM FOR YOUNG CHILDREN DELAYED IN ORAL COMMUNICATION SKILLS.

DOES YOUR CHILD...

- point instead of using words to express his needs?
- use gestures rather than words?
- know the names of familar things?
- have difficulty following spoken directions?
- have trouble listening to stories you read to him?
- use only single words or two word phrases?

REFER CHILDREN...

- who are between the ages of 1 and 6.
- who have difficulty with oral communication skills (such as the above).

TO: Miss Grace M. School, Project Director

Telephone: 739-3121

PRE-ACADEMIC PROGRAM FOR CHILDREN DELAYED IN ORAL COMMUNICATION SKILLS

TIMETABLE

SUMMER 1971 - Children referred will be evaluated and selected

FALL 1971 - Daily sessions will begin

STAFF
Grace M. School
Nancy Phernetton
Rolland Nock, Admr.

FUNDED BY
Appleton Public Schools
Wis. Dept. of Pub. Instruc.
Fed. Gov't. - ESEA Title 6-B

JOHNSTON ELEMENTARY SCHOOL

Appendix C

Appleton Public Schools-Kindergarten Round-Up-March
Speech & Lang. Disabilities Dept. Screening Record Form

School _____ Child _____
Birthdate: _____

C.A.

_____

I. Speech Evaluation (based on speech sample)

A. INTELLIGIBILITY - ARTICULATION

___Intelligible ___No apparent artic. error
___Mostly intelligible ___Some artic. errors_____
___Unintelligible ___Multiple artic. errors

TEST RESULTS

B. Voice Fluency

___Appropriate ___Appropriate
___Denasal ___Slightly nonfluent
___Other:_____ ___Extremely nonfluent

PPVT

_____

C. Grammar

_____ Sentence structure appears commensurate with C.A.

_____ Sentence structure appears immature

Gram. Closure

_____

D. Spontaneity

___Was spontaneous
___Talked when questioned
___Was nonverbal

RECOMMENDATIONS

II. Hearing - 25 db. (ISO) Pure tone screen using play audiometric techniques

___Passed screen-both ears
Failed ___right ___left

Recheck Hearing

_____

III. Speech & Language Disabilities Teacher's Speech & Language Follow-Up Recommendations

___ No follow-up
___ Complete speech and language diagnostic
___ Recheck in Fall

Comments:

Speech & Lang. Diagnostic

_____

M-Team Evaluation

_____

IV. Comments Offered by Parents:

Speech & Lang. Disab. Teacher:

_____

APPLETON PUBLIC SCHOOLS

Pre-Academic Program for Children
Delayed in Oral Communication Skills

Name: _____ Birthdate: _____

Parent: _____ Address: _____

Telephone: _____

REFERRAL

Date: _____
Referred by: _____
Reason for referral:

_____ Newspaper _____ Brochure _____ Other _____

INITIAL INTERVIEW

Date: _____ Interviewer: _____
Informant: _____ Relationship to child: _____

I. Information
A. Description of informants concerns:

B. Family data:
# of brothers older _____
# of brothers younger _____
# of sisters older _____
# of sisters younger _____
Fathers occupation _____
Mothers occupation _____
Child lives with: _____ both parents _____ other _____
Other speech problems in family:

How does child relate to sibs?

How does child relate to parents?

C. Developmental History:

1. Speech
babbled at age _____ did not babble ☐
First words at age ____ Uses gestures frequently _____
Informants description of present speech:

Speech problem first noticed by family _____
Does child like stories read to him? _____
Does child watch T.V.? _____

I. Information

How does child communicate his needs and opinions?

2. Hearing
(a) History of hearing loss? _____ Treated by _____
(b) Estimate of hearing levels at home _____

3. Motor Development and Growth

(a) Birth history or early infancy feed. prob., etc.:

(b) Milestones:

Sat at _____ Walked at _____
Coordination is felt to be _____
Balance is felt to be _____

4. Social Skills

Feeding _____ Uses: _____
Dressing: Off: _____ On: _____
Self-Help Skills: _____
Toilet training _____
Mother feels these skills developed at: _____
_____
Comments: _____
_____
In the neighborhood this child _____
Nursery school and other peer group experience include:

Teacher concerned about _____.

Child socially described as:

Social development is generally felt to be:

5. Medical History

History of illnesses and/or operations:

Any physical defects:

Is child presently on medication? _____
Comment: _____
_____
_____

Appendix E
Daily Newspaper.
Typed messages can
be done before clas

The Daily Express

Tues - Feb 19, 1974 — O.C.C - Johnston School

PARENTS! Remember the field trip to the Valley Fair Shopping Center is tomorrow. Please do not send money with the children. We will have a treat from the fund you provided. Three parents are accompanying us. We plan to be back by 11:30.

George Was Absent

George was not here, at school, today. He is sick. He has a bad cold. He will miss our field trip tomorrow. Too Bad!

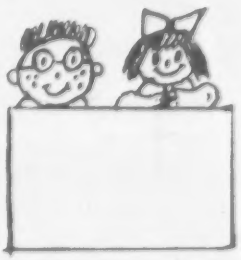
The boy is in the box

Who is on top of the

We saw slides of our field trip - What did you see Tomorrow we will see the fish in the pet store. What else?

Show & Tell

Boxes - Boxes - - -
where did we take the boxes (gym). Did you get in the box? Who got a ride in the box? Who was scared in the big dark box? (Andy) What did Andy do?



The boy and the girl are behind the box.

Where is the girl? (beside

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d.	Visual Learning	Norman A. Buktenica
e.	Verbal Learning	Nancy E. Wood
f.	Temporal Learning	Barbara D. Bateman
g.	Reading	Ruth Strang
h.	Writing	Elizabeth S. Freidus
i.	Arithmetic	Carl Bereiter
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